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OF THE
ACADEMY
OF
PSYCHOSOMATIC
MEDICINE

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1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

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2. Gesell, A., and Ilg, F. L.: *The Child from Five to Ten.* New York: Harper & Bros., 1946.

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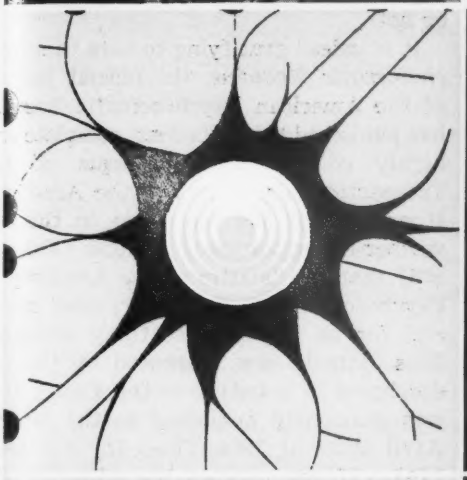

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Editorial

A Review of a Book Review

The *Transactions of the 5th Annual Meeting of the Academy of Psychosomatic Medicine* were reviewed by Dr. John A. P. Millet in the May-June 1960 issue of *Psychosomatic Medicine* (Vol. 22, #3, pages 238-240). This review has been reprinted on page 236 in the Book Review section of this issue, with the consent of the publisher and of Dr. Millet.

The reader may note that Dr. Millet states: "The title: 'The Psychosomatic Aspects of Internal Medicine' is unnecessarily tautological, since if internal medicine . . . is not concerned with the organism as a whole, it can hardly be considered worthy of rating as a specialty." Internal medicine is a specialty, and a worthy one, but despite Dr. Millet it has not been sufficiently concerned with the organism as a whole. Through the years there has developed an ever increasing need for the internist to "remain scientific" and to keep abreast of the newest and most esoteric tests and investigations. In this way he could continue to be a "good internist" and not fail to miss a single trick in his attempt to diagnose and thus understand the basis for his patient's difficulties. Unfortunately, this need is too often a unilateral one, in which the possible role of the emotions is frequently pushed aside, suppressed and repressed, so that the "scientific investigations" can continue.

In some instances, to be sure, only a temporary suppression and repression can be accomplished, since repressed material must seek expression. Even strict organicists who deny the existence of the psyche (often quite vehemently) can now accept it unconsciously, none the wiser for their breach of promise to do otherwise. They do not practice what they preach, nor do they preach what they practice. They might, on occasion, be found reassuring a frightened patient, without their realization that they were engaged in this type of "unscientific" relationship. Perhaps, in this light, the title becomes tautological, since all medicine is practiced on a total person, whether the doctor is aware of it or not.

It is indeed gratifying to note that *Psychosomatic Medicine,* the official journal of the American Psychosomatic Society, has published this excellent, complete and highly complimentary critique of the Transactions as well as of the Academy. It was almost five years ago, in the November-December issue of 1955 (Vol. 17, #6) that the "matter of the Academy of Psychosomatic Medicine" provided material for an unsigned scathing editorial. This "attack" was answered by the undersigned in a Letter to the Editor that was graciously published in the March-April issue of 1956 (Vol. 18, #2, page 174). If one reviews the editorial, the rebuttal and Dr. Millet's recent comments, it becomes obvious (at least to this admittedly prejudiced observer) that the Academy, although only seven years old, has shown some suspicious signs of maturity. Perhaps the "scathing" editorial referred to above was more constructive than destructive (both in content as well as intent); perhaps it provided one of the most necessary stimuli for the Academy's present growth and development.

Wilfred Dorfman, M.D.

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Contents

all of these patients have anxiety symptoms;

*but half need an antidepressant, not a tranquilizer

depression—a common problem in office practice...

"It is generally acknowledged that at least 40 to 50 per cent of the patients seen in private practice have emotional problems and that true depressions or depressive equivalents are found in more than half of these." Cooper, J. H.: J. Am. M. Women's A. *14*:98, 1959

anxiety often "masks" underlying depression...

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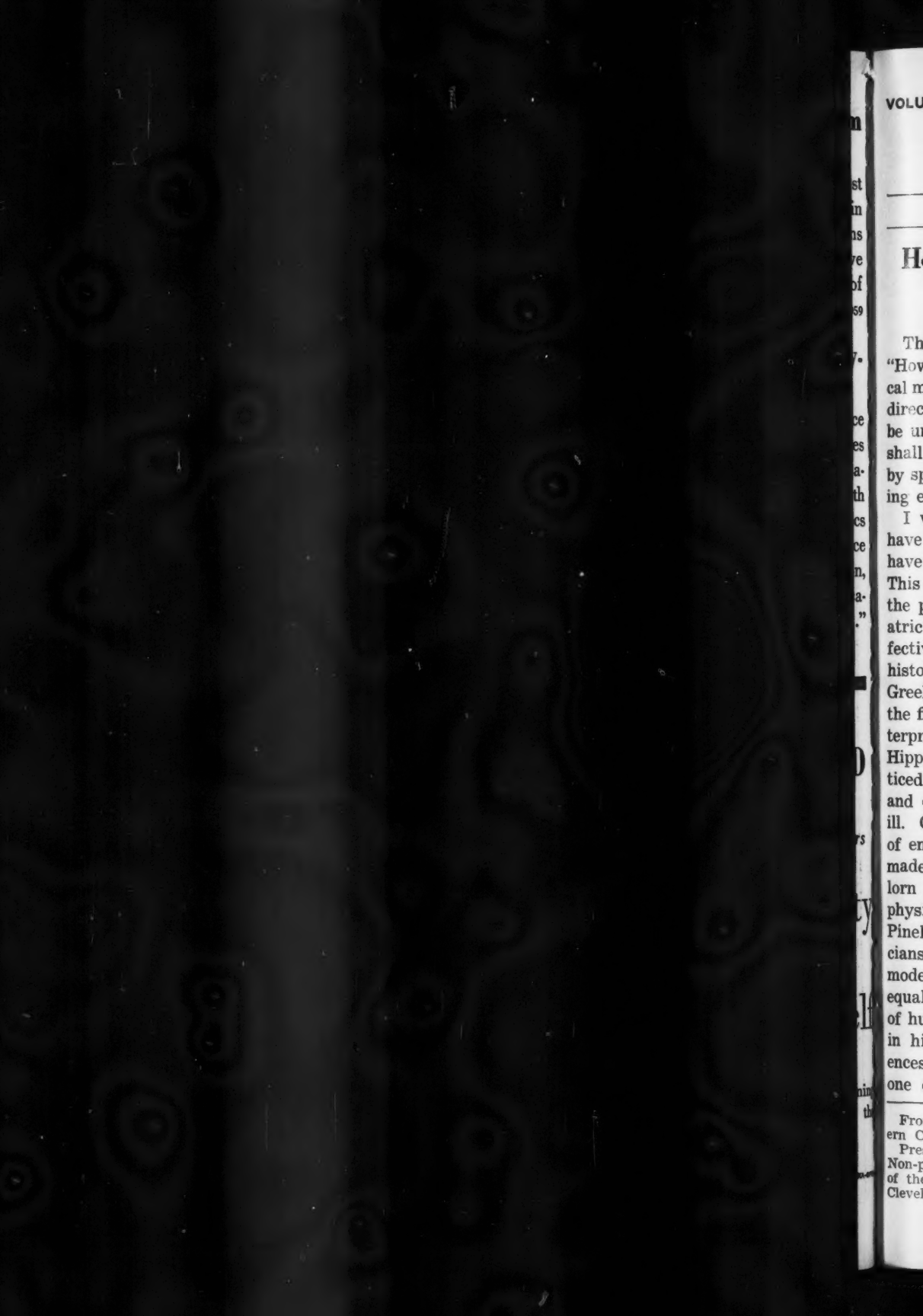

VOLUME I - NUMBER 4 JULY - AUGUST 1960

PSYCHOSOMATICS

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How Much Psychiatry Should the Non-Psychiatrist Do?

THEODORE ROTHMAN, M.D.

The question referred to in this panel is, "How much psychiatry should the medical man do?" I shall answer this question directly and bluntly. Of course, this may be unorthodox for a psychiatrist. But I shall retrieve my reputation soon enough, by spending the rest of my discussion being evasive but friendly.

I wish to begin by saying that there have been many great physicians who have contributed greatly to psychiatry. This tradition is ancient and begins with the priests of Aesculapius whose psychiatric treatments in their temples were effective according to the testimonial case histories that still can be read on elegant Greek tablets at Epidaurus. They were the first to use a sleep therapy and to interpret the dreams during this treatment. Hippocrates, an Aesclepiad himself, practiced much that today would be excellent and effective treatment for the mentally ill. Galen's awareness of the relationship of emotions and psychosomatic problems made him a popular physician among lovelorn women. He was also the personal physician of Marcus Aurelius. Philippe Pinel was among the significant physicians of his time and his contributions to modern psychiatry and medicine were equally revolutionary. His understanding of human beings transcended his century in his grasp of the socio-cultural influences of the hospital milieu. Charcot was one of the great physicians of history, with numerous contributions to pathology, medical diagnosis, nosology, neurology and psychiatry. Eventually, I believe, he will be considered one of the greatest psychiatrists of all time.

Therefore, I will venture an answer at once and state categorically that the man of medicine has always been in the field of psychiatry. He has held a place there from time immemorial. Some day I hope that psychiatrists will make as great a contribution to medicine as medicine has made to psychiatry.

What is best in psychiatry is what is best in medical practice. The highest goals of medical practice are the same for the internist, the generalist and the psychiatrist. In order to practice a specialty, the physician must have had special training. The man of medicine can only practice what he has been trained to do. In order for a generalist to practice some psychiatric therapies, he should have a good psychiatric training in medical school. He should also have appropriate post-graduate training in a clinic, laboratory and hospital to qualify him to manage psychiatric problems. His training shall have taught him his limitations and his potentialities. Therefore he will know what cases to undertake and what cases he would not be able to manage by the very nature of his training.

First, let us examine what the physician's training in psychiatry should be; second, what types of cases this training qualifies him to treat.

The physician should be trained in psychiatric nosology. This is common medi-

From Dept. of Psychiatry, University of Southern California.

Presented at the panel on Psychiatry for the Non-psychiatrist at the Sixth Annual Meeting of the Academy of Psychosomatic Medicine in Cleveland, Ohio.

cal practice. To treat without diagnosis is hazardous, especially in psychotherapy. Patients can disintegrate or commit suicide if the wrong treatment is prescribed. A physician cannot treat psychiatric diseases that he cannot diagnose. Here as elsewhere in medicine, treatment depends on diagnosis.

Then, of course, the physician should have the special knowledge and skill required for treating psychiatric cases. This means that the physician has to have training and experience with a variety of both somatic and the psychotherapeutic forms of treatment, knowing their potentialities and limitations. There are many forms of psychotherapy from the simplest persuasion and suggestion to the very complex psychoanalysis. He must learn various psychotherapeutic strategies depending upon the degree of specialization he wishes to practice. These skills must be taught to him in clinics and hospitals under supervision of qualified psychotherapists. The general practitioner can perform only certain types of minor surgery and he can learn only certain selected forms of minor psychotherapy, unless he wishes to receive the necessary training to become a trained psychiatrist.

For example, if a physician becomes proficient in hypnosis, he can learn to use it in connection with suggestion and persuasion for removal of symptoms or as a supportive measure. Prolonged exploratory hypnosis, however, is not only time consuming and involved but hazardous. To explore the biography of the patient in detail, is to release side-effects. Unless one knows how to manage exploratory psychotherapy, one may precipitate a series of reactions which may be hazardous to the patient. Intuitive psychotherapy is frequently another name for psychotherapeutic mismanagement. Wild psychiatry is as dangerous as wild surgery. One either learns through training to be a complete psychiatrist and treats some psychiatric cases with reconstructive psychotherapy, or one knows one's limitations and learns to use less complex supportive forms of psychotherapy. Skillful supportive psychotherapy can be learned by any good physician. It takes years of training to excel at this type of psychotherapy like any other medical discipline, but it is worth the time to learn a skill that gives the physician so much satisfaction and the patient so much relief. Exploratory psychotherapy, involving interpretation and prolonged study of the patient's biography, needs specialized training. Without this training, one is like a surgeon who can do only an appendectomy yet tries to operate on a brain tumor.

It is of equal importance that our physician receive special training in psychopharmacology. This will not come from reading advertisements, but in having a sober scientific approach. The field of psychopharmacology is still young and the experimental designs are crude and the reports are rife with errors.

The main purpose, as I see it, of using a drug is to overcome these psychophysiological barriers that prevent the patient from interacting appropriately with other human beings. One cannot, according to my favorite pharmacologist, Chauncey Leake, "make a muscle spit." Neither can we aid a patient with a disturbance of a psychiatric nature with a drug alone. A drug cannot take the place of appropriate interaction with other human beings. The function that we perform in the pharmacotherapy of emotional disturbances is to hit several target symptoms hard, hoping that this will bring closer an integration of the personality. Drugs may alter behavior, relieve disturbances or bring about desirable changes, but unless the physician has established a relationship with his patient of an appropriate psychotherapeutic nature, unless there is emotional support, unless things in the therapeutic situation begin making some sense to the patient, relief will only be partial and uncertain.

Psychopathology is a disturbed form of social communication that has been frozen by life experiences into a fixed pattern, producing habitual distorted behavior. A drug may relieve the anxiety involved in these patterns in some measure. The relief of the anxiety and its concomitant psychosomatic reverberations makes the patient more available for interaction. The previously frequent unrewarding experiences resulting in habitual distortions need to be changed through a new series of interpersonal interactions. The physician, not the drug, prepares the patient for these changes. In this fashion, the physician himself is the strongest drug in the pharmacopeia. If the physician helps the patient as a human being, showing interest, professional concern, understanding and occasional glimmers of wisdom, the patient's anxiety is reduced to tolerable levels. The patient now explores life with the emotional support of another human being who can be trusted. When drugs are combined with appropriate psychotherapy, certain types of patients can more easily find their way towards health. There are potentialities for getting well in each of us, no matter how badly mangled, that a dedicated physician can awaken.

The naive psychoanalyst who ignores the benefits that accrue from the rich variety of recent somatic treatments is blind to the full therapeutic needs of man and is ignorant of the complex etiology of mental disturbances. The physician who sees therapy as only giving a pill for every ill is ignorant of the essential needs and complexities of man. Let us remember what Paracelsus has aptly said, "The virtue lies not in the drug, but in the physician himself." What is required is a holistic approach to man's ills. Only this approach can benefit the patient as a human being and reward the physician by helping them both to encompass the human situation. Let us all—psychiatrists, psychoanalysts, internists, generalists, obstetricians, et al.—practice comprehensive medicine. In order to do this, one needs an integration of elements drawn from sociology, cultural anthropology, experimental psychology, biochemistry, neurophysiology, pharmacology, medicine and psychiatry. It is not a question of "organic" versus "psychogenic." It is truly a matter of the whole external and internal milieu of the patient. The issue is not "somatic therapy" versus "psychotherapy," but rather one of holistic therapy based on what well-designed experimental procedures have shown to be promising. One does not choose between psychoanalysis on the one hand and psychotherapy on the other, but rather from what is valid and useful in each of these approaches. Our goal should remain an evolving open system or a philosophy of science that encompasses many ways of helping that elusive creature, man. There is much that is new for all of us together to learn and explore. Meanwhile let us use wisely that which is presently acceptable, remembering always to seek for a better scientific methodology and for the best in a humanistic approach derived from the behavioral sciences and ethics. In this way we shall be true to the highest traditions of both ancient and contemporary medicine.

Therapy in stress disorders is a new continent still largely unexplored; there are some fairly well mapped areas, but much of it is simply blank space, with territory in between marked only by doubts, open questions and untested hypotheses.

Desmond O'Neill, M.D.

The Phenothiazine Tranquilizers - Their Neurological Complications and Significance

ALBERT A. KURLAND, M.D. and GEORGE F. SUTHERLAND, M.D.

The introduction in 1952 of chlorpromazine,[1] the first of the psychopharmaceutical tranquilizers for the treatment of the hyperactive psychiatric patient was not an unmixed blessing. Its limitations and complications had to be established by clinical trials and experiences. The complications of chlorpromazine soon made themselves known. These were certain types of neurological manifestations falling into the extrapyramidal group: jaundice; agranulacytosis; dermatological and vasomotor disturbances.

The clinical success of this product launched a great many investigations to find drugs which were more potent and caused less complications. Between 1955 and 1958, the following drugs in the phenothiazine group appeared in this order: the phenothiazines promazine (Sparine), mepazine (Pacatal), prochlorperazine (Compazine), trifluprómazine (Vesprin) and perphenazine (Trilafon). These compounds were the ones which remained after the pharmacological screening of hundreds of similar type compounds. It did not take long following the appearance of these drugs for the clinical investigator to begin to tabulate the type of complications resulting and how the drugs compared with each other. Some of the most extensive presentations to date in this area are those of Freyhan[2] and Ayd.[3]

It became of interest to further define these complications and their incidence during a double blind study utilizing a negative (inert) placebo and a positive (phenobarbital) placebo while comparing six phenothiazine drugs for clinical efficacy. These were the drugs chlorpromazine (Thorazine), promazine (Sparine), mepazine (Pacatal), prochlorperazine (Compazine), trifluprómazine (Vesprin), and perphenazine (Trilafon). The factor which made this presentation rather challenging was the screening which had taken place in an attempt to eliminate all patients between the ages of 18 and 65 who in some way might complicate the study with an organic state. This led to an exclusion of alcoholics, patients with acute and chronic brain syndrome, senile psychosis, court orders, and any other complicating organic conditions. Over an 18 month period, from the 3,000 patients admitted during this time, 212 were selected from the admission service of the Spring Grove State Hospital as candidates for phenothiazine therapy.

The patients placed in the study were treated in a double blind fashion by the psychiatrist on the service to whom the patient was assigned. All patients received medication parenterally the first two days of treatment with a set minimal dosage level of three ampules per day but with no maximum. On the third day oral medication was begun, and the doctor again followed a minimal level of three capsules per day but with no maximum and complete freedom to manipulate dosage as high as he wished. The medication was dispensed in similar appearing ampules and capsules. The capsules were of two sizes so that the physician could double dosage and increase the medication without getting involved in dispensing large amounts of capsular material. The dosage range of the medication is indicated in Table I.

TABLE I

Comparative Dosage for Phenothiazine Study

Drug	Parenteral (1st 2 days)	Oral (3rd day) Beginning of Minimal Dosage[4]	Capsule No. 1	Dosage No. 2
	mg./cc	mg.	mg.	mg.
Thorazine	25	300	100	200
Sparine	50	300	100	200
Pacatal	25	75	25	50
Compazine	5	30	10	25
Vesprin	25	75	25	50
Trilafon	5	24	8	16
Placebo (neg) Isotonic NaCl	1 cc		Lactose	
Placebo (pos) Sod. Phenobarb.	65	97.5	32.5	65

From Research Department, Spring Grove State Hospital, Baltimore 28, Maryland. This study was supported by N.I.M.H. Grant MY-2152.

Presented at the Sixth Annual Meeting of the Academy of Psychosomatic Medicine at Cleveland, Ohio.

Six weeks had been set for the period of the experiment for two reasons: one was associated with a research design, i.e. a major interest was to evaluate a short term phenothiazine treatment, and the other was associated with the administrative structure, i.e. most patients could usually not be kept any longer than six weeks on the admission service of the hospital because of the pressure of admissions. If they required longer hospitalization they were transferred to other services and since this would bring about a change in environment it was decided to terminate this evaluation. Data obtained prior to the transfer were included in the final analysis. However, the physician on the service could terminate the experiment at any time prior to the six weeks if he felt that the patient was not responding to the medication, developing complications of such severity that termination was indicated, or that the patient was showing suffiicient improvement and medication was no longer considered necessary.

Although there were 212 patients referred to in this study there were 21 patients who were excluded because of complicating organic states leaving a total of 191 patients. The data concerning the factors responsible for terminating the treatments are presented in Table II.

Twenty-two patients developed drug reactions that seemed sufficiently alarming to the treating physician to order discontinuation of medication. The drug was identified, and their neurological and other somatic complaints are tabulated in Table III.

TABLE II

Analysis of Factors Responsible for Terminating Treatment

FACTORS	No. Pts.	%
1. No Response or Worse	63	33
2. Transfers to Other Services	30	16
3. Transfers Out, Paroled or Discharged	29	15
4. Drug Reactions	22	12
5. Medication No Longer Needed	6	3
6. Receiving Full Term Treatment	41	21
Total	191	100

The incidence of extrapyramidal complications in our findings was then compared to those reported by Freyhan[2] and Ayd.[3] The findings are summarized in Table IV. The factors which make this particular comparison of interest are 1) that in the present study the patients were screened to eliminate organicity, and 2) the period of drug administration was relatively brief, namely six weeks. These factors provide an opportunity to determine the incidence of the most common of the phenothiazine complications in a screened group in contrast to the general findings referred to above.

The incidence and importance of the other complications will not be discussed in this paper. Emphasis will be on the neurological complications and their significance since this appears to be the complication which will be seen with increasing frequency as the potency of the drugs are increased. This is especially true of those compounds having the piperazine groupings in their structure.

TABLE III

Neurological and Other Somatic Complaints in a Comparative Phenothiazine Drug Study

	Placebo (Negative)	Phenobarbital (Positive)	Thorazine	Sparine	Pacatal	Compazine	Vesprin	Trilafon	Total
No. Patients in Each Drug Category*	26	25	23	24	21	23	26	23	191
Neurological Complications	0	0	0	0	0	1	4	8	13
Other Somatic Complications:	0	0	1	0	0	1	0	0	2
Dermatological									
Vasomotor	0	1	2	2	0	0	0	0	5
Blurred Vision	0	0	0	0	1	0	0	0	1
Leukopenia	0	0	1	0	0	0	0	0	1

*Excluding those in whom organic conditions were found.

TABLE IV

Comparison of Extrapyramidal Reactions Found by Freyhan, Ayd and at Spring Grove State Hospital (S.G.S.H.)

	No. of Patients			Dosage Range (mg.)			Extrapyramidal Reaction		
Drug Group	Freyhan	Ayd	S.G.S.H.	Freyhan	Ayd	S.G.S.H.	Freyhan	Ayd	S.G.S.H.
GROUP I*									
Chlorpromazine	69	100+	23	75-1200	30-1200	25-800	17.0	35.0	0.0
Trifluprom azine	25	100+	26	75-400	30-300	25-300	32.0	36.0	15.0
Promazine	60	100+	24	40-2000	50-1000	50-800	2.0	2.0	0.0
GROUP II†									
Prochlorperazine	68	100+	23	60-200	10-150	5-100	63.0	36.0	4.0
Perphenazine	22	100+	23	30-120	4-96	5-96	55.0	36.0	35.0
GROUP III‡									
Mepazine	22	100+	23	75-950	50-1000	25-450	0.0	1.0	0.0

*Straight Aliphatic 3-Carbon Atom Chain Group
†Piperazinyl Group
‡Piperidine Group

The neurological complications falling under the general heading of extrapyramidal symptomatology, which can be classified into akinesia, dystonia, akathisia, and parkinsonian reactions, have led to some interesting revelations. We know now that the older patients (especially those over 50 years) are most likely to have extrapyramidal reactions. Dystonic reactions and akathisia happen most often in the younger patient. According to Ayd[3] akathisia and parkinsonism happen three times as often in women as in men, while dystonia occurs twice as often in men as women. This susceptibility to extrapyramidal reactions has failed to substantiate some of the earlier thinking that patients displaying these types of reactions tend to show a better clinical course than those patients not showing such reactions.[4]

Presently at this hospital, in conjunction with the National Institute of Neurological Disease and Blindness, an epidemological survey is being conducted. The frequency of spontaneous parkinsonism in the relatives of patients susceptible to the extrapyramidal complications of the phenothiazine drugs is being compared with a control group of patients who show no such sensitivity. There appears to be a possibility that a difference will be found between theese two groups. If this proves to be so it may be that one of the by-products of the neurological complications will be the possibility of detecting individuals who may have a tendency towards developing a parkinsonian disorder. This would suggest that the clinician, in evaluating the patient for phenothiazine therapy, might well investigate the question of neurological disorders in the patient's background.

CONCLUSIONS

In a group of psychiatric patients receiving phenothiazine tranquilizers and screened to eliminate organic states, the incidence of extrapyramidal reactions was much lower for the drugs chlorpromazine, trifluprom azine and prochlorperazine than previously reported. The incidence for the drug perphenazine tended to remain at the same level.

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The Arthritic Personality

RALPH WOLPAW, M.D.

The concept of the arthritic personality is somewhat limited in that it applies in the main to rheumatoid arthritis, although the other forms of arthritis are covered to some extent by association. Unless otherwise mentioned, the discussion in this paper will be confined to rheumatoid arthritis.

Only in the last 25 years has the idea that psychogenic factors play some part in the production of rheumatoid arthritis received any credence. Thoughts about an arthritic personality have been of even shorter duration and neither of these concepts has been extensively investigated. Most of the studies have been limited in the number of patients, the period of time involved, and the sex of the patients, but all the reports seem to indicate that herein lies a fruitful field for further endeavor. The chief stumbling block seems to be that not only the patient but even the physician has difficulty in accepting an emotional involvement in what is apparently so completely an organic disease. The contention is that any unusual personality changes which are present in rheumatoid arthritis are secondary to it rather than primary factors in the production of the disease. This is a simple and natural conclusion, but the relatively small amount of work which has been done points in the direction of a more or less definitive arthritic personality.

The question arises of whether there are then two distinct personality pictures present: a "before" and "after" likeness in the nature of Dr. Jekyll and Mr. Hyde. It is a great temptation to accept such a theory because, insofar as can be determined, the "before" and "after" pictures show considerable variance at times. However, it is felt that the basic personality traits are the same but the situational outlook has changed in many ways so that the manifestations of these basic traits show considerable difference.

What is the patient with rheumatoid arthritis like? What is the basic emotional make up which gives the ultimate personality result? The patient has suffered a disruption in the early mother-child relationship so that the necessary emotional security has not been provided. He is left with strong dependent needs and he develops destructive feelings when these are thwarted. There is a failure to adapt to any change or stress with resultant somatic outlets. The arthritic has chronic, inhibited, hostile aggression which is relieved to some extent by discharge through personality trends. He has a chronic resentment, a sort of smoldering discontent which is manifested through physical activity and the serving of others, the domination of the family. But these characteristics are found in other conditions as well; they are not distinctive in rheumatoid arthritis alone.

How are they significant in the production of the arthritis? There are undoubtedly other things which, in conjunction with the above, tend to produce difficulty. Some of these are heredity, and somatic, traumatic, and infectious factors. It is probable that heredity plays the greatest part in predisposing the tissues so that when the noxious stress hits an end organ, it is the joints and other connective tissues rather than the colon as in ulcerative colitis, the stomach as in peptic ulcer, or the head as in certain types of headache. For various reasons, the shock organ is different and thus, the disease is different.

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The dynamics are interesting. The discharge paths for the chronic hostility and aggression are interrupted so that there is increase in muscle tonus or tension, and pain on motion with resultant limitation of motion. Initially, the changes are physiological and reversible but over a prolonged period, gradually become fixed and increasingly irreversible. As the disease progresses, the personality characteristics undergo the "after" change and the apparently relaxed, placid individual appears. Evidently, while the basic emotional factors remain, the disease has altered the outlook sufficiently so that there is a temporary armistice psychologically and all is serene for the moment. Instead of serving, he is being served; instead of dominating, he is being dominated, that is, being sheltered and protected. The patient has at least momentary security from these reactions. The arthritis becomes a crutch which is not easily withdrawn, he is back to the very early mother-child relationship which he has never wanted to leave.

However, as noted above, this is a temporary and fragile situation. The patient is overtly calm, rarely expresses or consciously feels anger, but covertly, the hostile feelings remain and it does not take very much to disturb the delicate balance. The patient claims to be shy and inadequate although he is very much aware of his body, considers it extremely significant, and tends to be unconsciously exhibitionistic. Some of the psychological symptoms are divulged as poor sleep and poor sexual adjustment with constant marital conflict being a serious underlying problem. In the women, there is a drive for masculine competition going back again to the domination of the family, both before and after the disease, the latter by being served.

Case 1. Mrs. G., a 57-year-old white woman had been crippled by rheumatoid arthritis for about three years so that she was almost a complete invalid, occasionally getting into a chair or going for an automobile ride, after considerable exertion on the part of her family to get her into the car. Literally speaking,, she was waited on hand and foot and was the center of attraction for her husband and children, some of whom lived with her, others immediately above her or close by. She was finally admitted to a chronic hospital because it was felt that she could be rehabilitated. When she was not served constantly and was required to perform certain activities for herself, she became morose, unpleasant, and belligerent and complained so vociferously and at such length that her children signed her out in less than one week. Her history is typical, with slight minor alterations, of many others who have solved problems with their arthritis and in whom the removal of the disease would be more painful and unreconcilable than its persistence.

Case 2. Mrs. W., a 62-year-old white woman dated her rheumatoid arthritis back about twenty years to a time shortly after the death of her only child from rheumatic fever. She had made a poor marital adjustment and her entire life was wrapped up in her lovely and talented daughter. Her husband had a wandering eye but her disease and his job kept him close to the line until she finally reached a point of such helplessness that a nurse was required. This gave him much increased freedom which he made no attempt to conceal. She declined rapidly, entered a hospital, and died shortly thereafter. Aside from the changes of rather advanced rheumatoid arthritis autopsy did not reveal a specific cause of death. In this patient, the arthritis served a purpose, and when this disappeared, she did not improve, as happens in some cases. Instead she turned her destructive feelings inward, and, in a sense, faded away.

Case 3. Mr. C. was a 54-year-old white man who had rheumatoid arthritis for several years but had been able to carry on his regular activities as a social worker for a public agency. He had never married and lived with three maiden sisters, two of whom had rheumatoid arthritis. He had one other married sister who also had rheumatoid arthritis. In the course of treatment, he developed a bacterial infection of one knee, and, although this responded to antibiotics, he remained bedridden. It appeared that he had lost his spark, there was no incentive, he became progressively weaker and apathetic. His general resistance seemed to evaporate completely so that he developed decubitus ulcers from the slightest pressure anywhere on the body. He finally died from septicemia and meningitis the organism being a different one than had been in the knee. Heredity was the obvious specific factor in the production of disease in this man, al-

though the abnormal family relationships involving a substitution of sisters for the dominant mother, played a definite part. The final dissolution was associated with separation from the family for a long period of time because of the hospitalization with an inability to adapt to change and stress.

In conclusion, it is my feeling that there is a definite arthritic personality. It is not absolutely specific for arthritis; the basic elements are found in a number of other disease conditions and it has been called schizoid in type. However, when other factors such as heredity, trauma, and infection enter in along with additional factors which are more obscure, the resulting personality characteristics, allowing for a "before" and "after" situational change, can be quite readily discerned. This is not to say that the cause of rheumatoid arthritis is completely psychogenic; it is to imply that emotional changes are extremely important and they deserve careful consideration and further investigation.

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RELIEF OF PREOPERATIVE ANXIETY.—The relief so clearly verbalized by the patients after the sharing of anxieties, ridding themselves of misconceptions and getting the needed concrete information (unassimilated in the examining room), would indicate that the contact alone, with its grant of freedom to talk, has had important meaning for them. Presumably any hospitalization for surgery would have its own patterns of meaning for any given individual, including the psychosomatic implications of each particular illness. A few patients sail through operations with smooth mastery. It is the average patient who needs reassurance and a chance to balance her fears against reality, and the seriously disturbed patients who vitally need support for anxieties only indirectly related to the operation itself. A consideration of such needs should be incorporated in any goal of comprehensive medical care.

S. H. Sturgis, M.D., and H. S. Robey, M.A., M.S.
Connecticut Medicine, December 1959.

Behavior Problems and Brain Damage in Children

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Certain abnormalities of behavior form a pathognomonic pattern in children with brain injury. These deviations, though not always present, are so completely characteristic that many observers consider them part of the brain-damage syndrome.[1-3] Among these abnormalities are hyperactivity, perseverative motor movements, poor coordination, defects in symbolic learning, sudden changes in mood and a short attention span. It is less commonly known that children ostensibly normal, presenting as problems in behavior, may be considered suspect as regards brain damage, and that in many instances these suspicions are founded in fact. The purpose of the following discussion is to emphasize that many children who because of behavior disorders come to the attention of clinicians, psychologists, or psychiatrists, may have an underlying organic problem that must receive consideration in order to be able to understand or to modify the abnormal behavior presented.

Injury at Birth

Children with cerebral palsy form an ideal group as a point of reference, since the symptoms and signs of this disease are regularly recognized and there is complete agreement among clinicians that brain damage is the prime etiologic factor. Although there are a multitude of minor causes, the major cause of such brain damage is injury occurring at, or about the time of birth. Most of these injuries are also the result of cerebral anoxia that is due to one or another of many pathologic conditions. One of the most common is separation of the placenta, resulting in asphyxiation of the fetus. Similar asphyxiation occurs when the prolapsed cord is impinged between the head of the fetus and the pelvis of the mother. True knots of the cord, the cord wrapped around the neck, tears in the placenta, and placenta previa likewise result in anoxia of the brain of the fetus. Premature delivery, precipitous delivery, unduly prolonged or traumatic deliveries are also common etiologic factors. I have never been impressed with the soundness of correlating forceps delivery, particularly mid- or high-forceps delivery, with brain damage. The correlation, I believe is better linked to the mode of application of the forceps than it is to the pathologic condition present which requires such a forceps delivery.

Signs and Symptoms

Subsequent to delivery, certain pathognomonic signs indicative of brain damage or cerebral anoxia are often present. The typical state of asphyxia pallida and the necessity for prolonged attempts at resuscitation need no comment. More important perhaps are the lesser signs of brain damage; such a sign is the failure of a child to suck at the nipple. Sucking is one of the most primitive reflexes in the newborn human infant and it is common for the vigorous, normal, newborn baby to present with an active sucking reflex even before he is completely born. It is also common, on the other hand, to hear a mother say: "He doesn't know how to feed," or "I had to teach him how to hold his tongue." The infant who does not know how to feed is an infant in trouble.

Similarly swallowing is a primitive reflexive function; one that is thoroughly mastered and easily and smoothly carried

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out by the very youngest of normal babies. A child who chokes and gasps and has great difficulty with swallowing is a child who either has a congenital abnormality or cerebral damage that interferes with neuromuscular functioning. The common complaint of "mucus" is often underestimated. Aside from the accumulation of fluids that occurs in the most immediate neonatal period, this so-called "mucus" is not something that has been aspirated during the process of delivery, but is normal saliva that is inadequately taken care of by the pharynx. A child with this difficulty has, in reality, cerebral palsy that involves his pharyngeal muscles and the muscles of his tongue. These dysfunctions are frequently followed by drooling in later childhood, and also by speech defects.

A fourth characteristic of the infants who have suffered brain damage is the presence of paroxysmal irritability or fussiness, a disordered pattern of sleep, and constant or frequent crying. In most instances these children are thought to have "colic," and in all a great variety of formulas are used, and usually credit for success is given to the last formula used or to the last doctor consulted before this symptom disappears. It should be noted that we do not claim that all colic is the result of brain damage; we do wish to point out and emphasize, however, the frequent occurrence of great irritability in brain-injured children.

In subsequent years, particularly after walking has been accomplished, hyperactivity is a characteristic of behavior seen in the brain-injured child. It is impossible to define a borderline between that which is normal and that which is abnormal concerning hyperactivity. The extremes, however, are unmistakable. Such children are constantly on the run. It is impossible for them to sit still for any prolonged time. Frequently it is difficult for them to sit through a meal. In their speed and restlessness they are apt to be destructive, although destructiveness itself is not part of this syndrome. The parents of the overly active child have usually learned to put away their own breakable treasured possessions and not to invest in expensive lamps. Climbing and jumping are, in particular, favorite activites. One mentally retarded chld, recently examined, spent the entire time in the examination room climbing to the top of the examining table, standing erect and jumping off to the floor, holding a filled specimen bottle in his hand. This caused much apprehension on the part of the observer but was taken in stride by the mother whose long experience had led her to regard such behavior with equanimity.

Disturbed patterns of sleep are another manifestation of the hyperkinetic state. These may vary from extremely early rising to an inability to sleep more than a few hours at a time with a great deal of noisy and boisterous behavior interspersed in the night hours, making life unpleasant for all other members of the family.

Unusual lability of mood is also seen in the brain-injured child. Temper tantrums are frequent as well as easy swings from excessive happiness to great unhappiness. These mood changes are often as short-lived as they are intense. They resemble in many ways the mood changes seen in children with acute Sydenham's chorea.

Aside from the readily observable abnormalities in motor function that are present as a result of cerebral palsy, there are certain other minor variations in motor function which can be observed and are quite characteristic of brain damage. Among these are repetitious motor patterns such as clapping of the hands when excited, happy, or annoyed. Other stereotyped hand-waving patterns may be present. Most individuals who have cerebral palsy will have poor coordination in all motor functions over and above the major disorders presenting, such as impaired visual-motor coordination. Poor coordination of the muscles of speech may pro-

duce disordered speech patterns. These usually bear an historic relationship to the prior difficulty of sucking or swallowing. Disordered patterns of symbolic learning are likewise common, and problems in reading may be a primary complaint. Disordered language development may range from simply poor speech to total aphasia.

On psychologic testing, patterns suggestive of brain damage may emerge. The most common pattern seems to be the unusually inconsistent and variable results on a battery of standard tests. Intelligence in the brain-injured individual presents itself in a checkerboard fashion, with the individual being average or above average in certain aspects of learning and definitely subnormal in others. This feature makes it difficult to present accurately a single intelligence quotient on a given individual. The short attention span is another characteristic shown by psychologic testing, and difficulties in abstract reasoning are other characteristics brought out. Visual-motor functioning is also impaired as evidenced by the child's difficulty in graphically reproducing geometric designs.

In certain instances the child who presents as a "behavior problem" may prove to have brain damage as a significant etiologic factor in his abnormal behavior. The following two selected cases illustrate this point.

Case 1 C.D., a girl, was first examined at the Cleveland Clinic at the age of seven years because she "rebelled against everything." She was the oldest of three children; the siblings, a girl aged five and a boy aged two, seemed entirely normal. The parents were intelligent people who seemed completely happy and normal in their family relationships. This child was described as "always into things, always climbing, extra-nervous and very moody." Her grades in school were average but she was threatened with exclusion because of her uncontrollable behavior. The background history revealed that the pregnancy was normal but the delivery was unusually long and difficult. The membranes had ruptured several days prior to delivery. The child was difficult to feed and seemed "lazy" in sucking. Considerable mucus and fussiness were present for the first three months of life. She walked at 13 months and her general development seemed normal; however, hyperactive behavior was evident from the time she began to walk.

The physical examination revealed no abnormalities other than the fact that she was unusually thin and that she had some difficulties in fine coordination as evidenced by her difficulty in copying simple designs. Psychometric testing was done using the Stanford-Binet Form L. Her I.Q. was 93. Her basal accomplishment was at age five years with effort through eight years. Immediate memory span was her most difficult item. She was cooperative but was easily distracted and her attention was difficult to hold. The electroencephalogram showed diffuse dysrhythmia with bilateral synchronous 4 per second waves with voltages of 75 and 100 microvolts (Fig. 1).

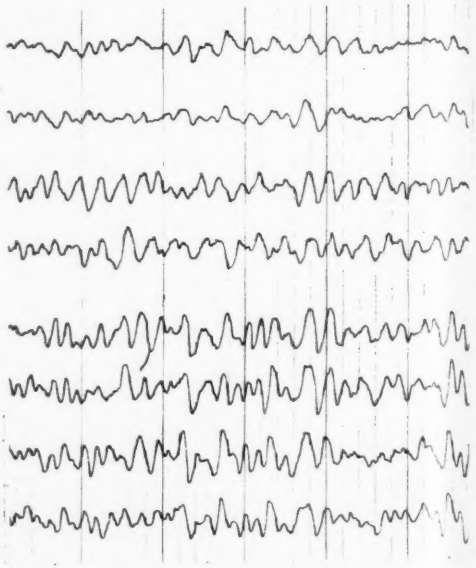

Figure 1

It was our opinion that this examination revealed primarily organic hyperkinesia with little evidence of psychogenic disturbance. Dilantin (diphenylhydantoin sodium) was prescribed but brought about little change in her hyperactivity.

Case 2. R.M., a boy, was first examined at the Cleveland Clinic at the age of seven years and six months. The presenting complaint related to frequent episodes of tonsillitis, but further

history brought out the important factor of a "Behavior Problem." He was the second child born in a family of two children. The older sibling was physically well, dong well in school and not in any apparent difficulty. The patient however was known to be the neighborhood "bad boy." He was usually placed in a secluded position in the school room to prevent his interference with other children. The child had been excluded from one school system because of his behavior. He was constantly fighting, extremely defiant of his parents and of others in authority, given to temper tantrums and aggressive behavior. His mother described him as being "blackballed" by the neighborhood.

The mother was observed to be an emotionally unstable person. She was in tears during most of the interview and readily confessed her total inability to handle this child. She sorrowfully expressed feelings of inadequacy and guilt over her role in the production of the child's behavior problems. The father was thought (by the mother) to be an ineffective and unstable person. There was a long background of his own inability to hold a steady position, and frequent moves and many unexplained absences from home on his part. It was noted that the child's behavior was less malicious when the father was away from the home.

A review of the background history revealed what was thought to be a normal pregnancy and delivery. However, from the time the child was born he had extreme periods of fussiness and crying. This was thought to be colic, and multiple changes in formula were used with little success. The prolonged crying at night caused both parents to lose sleep and brought complaints from the neighbors. The statement was made by the paternal grandparents that this mother did not know how to take care of babies and that she did not want this child. In spite of the problems throughout infancy this child walked at 11 months. His behavior was marked by overactivity from the time he began to walk.

Physical examination revealed no major abnormalities. He was, however, markedly hyperactive and fidgety. He did cooperate with the examiner. Mild abnormalities in coordination were noted. Psychometric testing using the Stanford-Binet Form L revealed an I.Q. of 108. He appeared tense and had diffifficulty in concentration. A basal age was established at six years with effort through nine years. His failure at seven years was in immediate memory span. The electroencephalogram showed a dominant rhythm of 9 to 10 per second alpha activity. During hyperventilation there was a prompt appearance of paroxysmal slow wave activity with high amplitude. Occasional brief runs of high amplitude slow waves of a paroxysmal nature were noted in the post hyperventilation period (Fig. 2).

It was our impression that this boy had hyperkinesia on the basis of organic brain damage superimposed upon which were serious problems of an emotional nature. A trial course of meprobamate was of no avail. Dilantin was prescribed and brought about moderate control of hyperactivity. The child was seen and followed briefly at two separate child guidance centers. On each occasion the parents terminated the contact because of their dissatisfaction with the psychiatrist. When last examined, at the age of 10 years, there seemed to have been considerable spontaneous improvement.

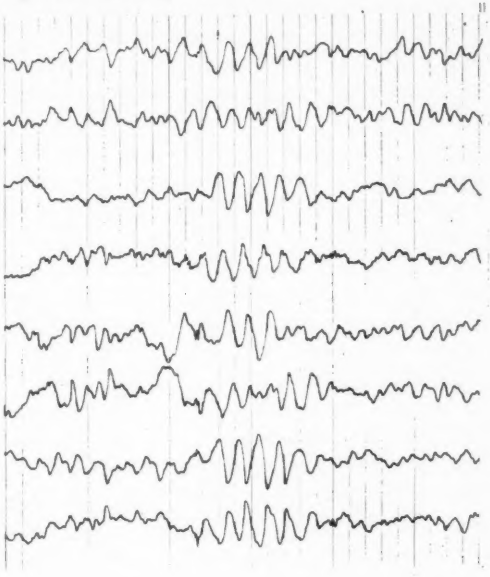

Figure 2

DISCUSSION

The ostensibly normal children whose problems have an underlying organic factor, usually come to clinical attention in the early school years. A careful history of the birth, neonatal and early infancy periods will reveal facts suggestive of brain damage or brain irritation in most cases. Difficulties in sucking, swallowing, sleeping and unusual fussiness or "colic" are related in most such histories. The paradoxic occurrence of a child with unusual feeding difficulties in a family

where the mother has already demonstrated her competence in raising other children should first evoke the suspicion that something is wrong with the child, not necessarily with the parent. Unfortunately this is not the usual sequence, and instead the suspicion first is raised that there is something wrong with the mother's relationship to this child, and her adequacy and motives accordingly are questioned.

On physical examination, these children with subtle brain damage demonstrate little clinical abnormality. The rate of neuromuscular development is usually along normal lines. Many children may have even an accelerated developmental pattern and walking may be accomplished early. Fine motor coordination, however, is often poor and it is unusual for these children to excel in athletic ability. Dexterity in writing is likewise difficult to accomplish, and these problems in coordinated muscular activity can readily be demonstrated by requesting the child to copy simple patterns such as a square, a diamond, or a circle.

Mental retardation is not a problem with these children and the actual intelligence quotient may be anywhere within the normal range. Psychologic testing, however, is characterized in all instances by an unusually wide span of accomplishment, and short attention span is common as are difficulties in abstract thinking, reading and speech. Reading is a particularly important aspect to this problem since specific problems in this area often are unrecognized, leading to failures in school and notable frustration on the part of the child.

Superimposed on the basic pattern of brain damage in hyperactive children is the frequent presence of marked emotional disorders both in the child and in the family of the child. Delinquent behavior such as lying, stealing, undue fighting and sexual promiscuity is also seen.

Overwhelming feelings of guilt on the part of the mother are usually seen; she has become convinced of her inadequacy because of her failures with her hyperactive child, and doubts as to her feeling of love toward her child will have occurred to her. Conflicts within the family become paramount. Unhappiness and strife between the mother and the father are common. The near relatives usually enter the scene and contribute in a damaging way to the general emotional turmoil. The emotional factors multiply, and finally that problem which started out as one of atypical behavior as a sequel of brain damage becomes submerged in pathologic behavior on an emotional basis.

Unfortunately a new difficulty now arises in attempting to give the parents some insight into their problems. Usually by the time they consult their physician they have become so deeply involved in the emotional aspects of the problem that they will avidly grasp at any organic explanation that will relieve them of their feelings of their own inadequacies or failures. Often the concept of the organic etiology is grasped to the complete exclusion of insight into the emotional side of the problem. This is most unfortunate since the organic problem is frequently not treatable and the emotional problem is amenable to help.

In regard to drug therapy for the hyperkinetic child, we have been most disappointed with the use of tranquilizers and sedatives. On occasion, one or another of the tranquilizing drugs will give wonderfully satisfactory results; more often than not, they fail of their purpose. Curiously enough, the administration of phenobarbital will frequently aggravate the hyperkinesia. The reason for this is unknown, but it perhaps is related to the known ability of phenobarbital to produce abnormalities in the electroencephalogram. Dilantin will sometimes produce a striking improvement. Amphetamine is more likely to be helpful, and in some instances the response is most dramatic and

is thought by some clinicians to be specific for this syndrome.[3] The passage of time and the maturation of the brain fortunately tend to lessen the importance of organic hyperactivity in the later teen-age years.

SUMMARY

The characteristic behavior of brain-damaged children has been discussed. The fact has been emphasized that in our experience many individuals presenting primarily as problems in hyperactivity or behavior have as an underlying etiologic problem the presence of organic brain damage. The background history of hyperactive children often suggests the presence of birth injury, and electroencephalograms frequently confirm the presence of cerebral dysrhythmia. An understanding of the organic factors involved seems basic to the treatment of the behavior problems.

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Why does a patient complain of a trivial symptom—and then, after allowing the doctor to make a full examination and even complete the prescription, venture to mention a more serious symptom in a light-hearted manner? . . . Questions relating to the behavior of patients can only be answered when it is realized that the doctor's help is often sought by the patient for another and deeper purpose—a purpose connected with the restoration of mental balance which has been upset by circumstance, accident or disease. . . . It is as if the patient's mind needed a stabilizer to restore its lost balance . . .

The practitioner must study his patient as a whole; noting his background, his behavior, his dress, his time of coming to the surgery or of asking for a visit, his method of presenting his case, his choice of words and use of adjectives, and the last words he says at the end of a consultation. The practitioner must observe too the moments of tears as well as of laughter, and the moments of embarrassing silence as well as those of eagerly expressed emotion. . . .

If the practitioner does not recognize his role of "stabilizer" as well as his other role of "master of the art of diagnosis and treatment of organic disease," he will be led into a collusion with his patient to talk about everything except the patient's real problems, and will waste time and money trying to exclude organic disease where its existence is not really suspected. If the practitioner asked himself such questions as "Why has this patient come to see me today for a pain that has been present for five weeks?" and "What possible organic disease can be present to account for this pain?" he would soon see when his role was to stabilize and when it was to act as a killer of germs, and he could come to recognize more easily the stress disorders that masquerade as organic disease.

S. Pasmore, M.B., B.S.
The British Journal of Clinical Practice, May 1959.

Emylcamate*, A New Tranquilizing and Muscle Relaxant Agent

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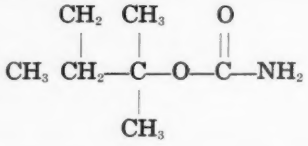
Anxiety, tension, muscular spasm and pain, whether organic or functional in origin, are part of a vicious cycle that perpetuates physical and emotional states now so familiar that they are considered inherent in our society. The chain of events may be precipitated by acute trauma. Patients complaining of these symptoms offer a constant challenge to the medical profession—in fact, they consume a large portion of time of both general practitioners and specialists. There are available a large number of compounds that are recommended for and used in the management of these patients. This in itself is proof that none of the drugs is entirely satisfactory and that the need for new agents, more effective in relieving the symptoms, still exists.

In a pilot study, a small number of patients suffering from anxiety, tension or muscle spasticity were treated with a new, recently synthesized agent, emylcamate, which, because of its tranquilizing and muscle-relaxing actions, was recommended for the treatment of such disorders. The promising results were obtained in the early studies indicated that the drug deserved further clinical evaluation. The scope of our study, therefore, was enlarged to include experiments which would assess the therapeutic value of emylcamate in comparison with meprobamate (Equanil, Miltown), a popular agent, which has been proved clinically to possess potent tranquilizing and muscle-relaxing properties. The results of these studies are reported in detail.

*Emylcamate (Striatran) used for this study was supplied by the Medical Research Division of Merck, Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa.

CHEMISTRY

Emylcamate is the carbamate ester of the tertiary alcohol, methylpentanol. Its chemical name is 1-ethyl-1-methylpropyl-carbamate and it has the following structural formula:



Emylcamate, a white crystalline compound, melts at 56 to 58 C., with a barely perceptible camphor-like odor. It is slightly soluble in water and very soluble in organic solvents.

PHARMACOLOGY

In laboratory animals[1] emylcamate depressed transmission through internuncial pathways of the central nervous system. The drug selectively reduced reflexes mediated by polysynaptic neuronal pathways but did not depress monosynaptic reflexes. Electroencephalograms recorded in neuropharmacologic studies of cats and monkeys showed slowing of spontaneous activity, but the drug did not interfere appreciably with alerting responses elicited by sensory stimuli. Changes characteristic of an anesthetic effect were not noted. Toxicologic studies revealed no adverse effects of therapeutic dosage in man.

Swedish investigators,[2-4] studying the comparative activities of emylcamate and meprobamate, concluded that emylcamate produces satisfactory therapeutic effects on significantly lower dosage than does meprobamate and that it has a more rapid onset of action. The duration of action of single doses of these preparations in equivalent amounts appears to be similar.

Because of inhibition of internuncial transmission, emylcamate induces relaxation in the spinal cord. It relieves anxiety and tension entirely, although in relatively large doses it produces drowsiness due to central depression. Metabolism and excretion of this preparation have not yet been elucidated although it is postulated that the drug is destroyed at least partially in the liver.

CLINICAL STUDIES

All patients studied presented symptoms which would probably require at least several days of treatment. The subjects were divided into two groups. Group I comprised 123 hospitalized patients and 38 office patients. They were given all three drugs—emylcamate, meprobamate or a placebo—during their treatment, the order of administration of the drug being selected at random. Patients in Group II received emylcamate only. In addition to 60 office patients, this group included 19 hospitalized subjects who received emylcamate preoperatively or during labor.

Substitution of emylcamate in some of the office patients in Group II who had previously been treated with meprobamate for prolonged periods afforded an opportunity for comparison of the relative efficacy of the two drugs.

TABLE I

Distribution of Patients

Diagnosis	*No. Pts.*
Organic Spastic Muscular Conditions	
Skeletal muscle strain (including low back strain); Fractures	60
Joint disorders (dislocation, sprain)	11
Bursitis	6
Torticollis	3
Myalgia; myositis	8
Pruritus	2
Acute cholecystitis	2
Coronary occlusion (acute?); angina pectoris	3
Labor	6
Neuralgia; neuritis	4
Protruded intervertebral disc	2
Osteoarthritis	4
Ureteral calculus	1
Total	112
Psychosomatic Disorders	
Preoperative tension	13
Anxiety states	60
Labile hypertension	3
Ulcer-like symptoms	3
Spastic colitis	3
Angina-like pain	2
Low back pain (etiology unknown)	4
Nausea	3
Irritability	6
Stuttering	2
Premenstrual tension; dysmenorrhea	4
Asthma	4
Paresthesia	1
Urinary retention (functional)	1
Threatened miscarriage	4
Melancholia (depression)	4
Total	117

Dosage and Duration of Administration

The three drugs were given orally in identical yellow capsules, unidentifiable either by patients or nurses. The usual dose of emylcamate was 200 to 400 mg. three or four times daily. Meprobamate and the placebo were administered in doses of 400 to 800 mg. two or three times daily. Duration of treatment of hospitalized patients ranged from one to six days with emylcamate and meprobamate and from one to four days with the placebo. The average duration of treatment was respectively, 4.1, 2.4 and 2.0 days for the three drugs. Office patients received emylcamate or meprobamate for 1 to 60 days and the placebos for two to four days. The average duration of treatment was approximately 20, 26, and 3 days, respectively.

Standards of Evaluation

Results of therapy were termed excellent when all symptoms disappeared completely; good when only minor residual symptoms or infrequent relapses were observed; fair when the patient experienced only partial, but appreciable relief; and poor when the drug produced slight effects or none.

Results of placebo administration have not been tabulated. In more than 85 per cent of the patients both emylcamate and meprobamate produced significantly better results than did the placebo. The so-called placebo effect, noted by others,[5] was not apparent in our study.

RESULTS

The various conditions treated and the number of patients in each group are recorded in Table I. The results are tabulated in Table II. In Group I emylcamate produced excellent or good results in more than 85 per cent with organic or psychosomatic complaints and also in those with mixed symptoms while meprobamate showed excellent or good results in 65 per cent of the patients in all groups. We believe that the differences are large enough to be significant.

The results indicate that emylcamate possesses potent tranquilizing and muscle-relaxing effects in selected patients, and often insures a smooth postoperative course, easing hospitalization.

The administration of emylcamate potentiated to some degree the pain relieving effects of the narcotic agents codeine, meperidine and anileridine. In several instances the dosage of the narcotic agent was reduced by one-third or one-half when emylcamate was added to the therapeutic regimen. This clinical observation indicates the need for further study. Antihypertensive therapy with chlorothiazide seemed more effective when emylcamate was added with some relaxation of associated nervous tension.

Because of the unusual calming effect of emylcamate and the absence of serious undesirable reactions following its admin-

TABLE II

*The Therapeutic Efficacy of Emylcamate in Anxiety, Tension and Muscle Spasm Due to Organic or Psychosomatic Causes**

Diagnosis and Results	GROUP I Comparison of emylcamate with meprobamate				GROUP II Administration of emylcamate only	
	Emylcamate Patients		Meprobamate Patients		Patients	
	No.	%	No.	%	No.	%
Organic Spastic Muscular Conditions						
Excellent	28	44.4	18	28.5	43	81.1
Good	26	41.3	24	38.1	3	5.7
Fair	7	11.1	13	20.6	3	5.7
Poor	2	3.2	8	12.8	4	7.5
Total	63		63		53	
Psychosomatic Disorders						
Excellent	40	43.9	12	13.2	15	55.6
Good	41	45.1	46	50.5	6	22.2
Fair	6	6.6	23	25.3	3	11.1
Poor	4	4.4	10	11.0	3	11.1
Total	91		91		27	
Mixed Symptoms						
Excellent	64	45.4	29	20.6	57	72.2
Good	58	41.1	64	45.4	9	11.4
Fair	13	9.2	34	24.1	6	7.6
Poor	6	4.3	14	9.9	7	8.8
Total	141		141		79	

*Patients presenting indefinite symptoms suggesting both organic and psychosomatic causes with clear-cut diagnosis impossible, were listed in both groups.

istration, the rapid recovery of the patient was induced, allowing him to direct his energies into more purposeful channels. The relief of muscle spasm and pain permits early resumption of productive activity. Alleviation of anxiety, tension and muscle spasm provides a smooth course for the hospitalized patient and promotes better patient-staff cooperation and efficiency.

In conclusion, the administration of emylcamate produced satisfactory results in more than 85 per cent of the patients treated for anxiety, tension or muscular spasticity due to organic or psychosomatic causes.

SIDE EFFECTS

Side effects are tabulated in Table III. The incidence of undesirable reactions was negligible. The most frequent side effect was drowsiness which was considered advantageous in hospitalized patients. In some cases a soporific effect was induced deliberately by increasing the dosage. Patients became easier to deal with, which in turn facilitated nursing care.

The sedative effect was not apparent in ambulatory patients and all subjects were able to continue their daily routine without interruption. All side effects disappeared immediately when the administration of the drug was discontinued. Most reactions responded to symptomatic treatment.

Complete blood count, urinalysis, blood pressure and pulse measurements were made repeatedly in approximately one-third of the hospitalized patients. No abnormalities were noted.

Emylcamate induced no habituation, addiction or tolerance. Morning "hangover" attributable to the drug was not observed in any patient.

TABLE III

Side Effects of Emylcamate

Symptoms	*No Pts.*
Drowsiness*	31
Nausea	4
Vomiting	2
Dizziness	2
Increased anxiety	1
Paresthesia	1
"Heartburn"	1
Headache	1
Total	43

*Produced deliberately in 22 patients by increasing the dosage.

SUMMARY

1. Clinical trials with emylcamate, a recently synthesized drug with effective muscle relaxant and tranquilizing properties are reported.

2. The chemistry and pharmacology of the drug are presented briefly.

3. The comparative effects of emylcamate and meprobamate were evaluated by the double-blind method in 200 hospitalized and ambulatory patients presenting symptoms that indicated possible benefit from these drugs.

4. Emylcamate proved effective in more than 85 per cent of the patients.

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Dangers of Indiscriminate Permissiveness

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Trends in therapy and casework are necessarily conditioned by our philosophy of life. Each generation reacts against the preceding one, and is overaware of the failings of their parents' contemporaries. The peak of the antivictorian reaction seems to be passing, and it is time to take stock of the situation. The last twenty or so years of modern casework, progressive education and psychotherapy were dominated by antiauthoritarian and antidisciplinary trends, the tendency to protect patients and children against any sort of pressure and frustration. While this approach has been justified with certain patients, it has proved a failure, and sometimes a dismal one, with others.

The concept of permissiveness as therapy makes sense only if we assume that every patient is a victim of overstrict repressiveness, a cowed individual with an irrational sense of excessive inferiority and insecurity stemming from an unhappy childhood. With such patients, encouragement and permissiveness is justified and is likely to yield good results.

However, many patients have not been brought up restrictively. In fact, it may be questioned whether the present day liberal education has not produced as many or more abnormal persons as Victorian overstrict standards. Also, sometimes the sense of inferiority is not irrational, but justified by the patient's behavior or caused by the disproportion between his ambitions and his ability; it is the outcome and not the cause of his maladjustment. Moreover, other attitudes, such as ideas of grandeur may be more pathogenic than a sense of inferiority.

Uncritical and indiscriminate support on the part of the therapist is as undesirable as narcissistic overprotectiveness on the part of a parent; it confuses the patient's sense of reality instead of developing it. The patient's feelings of inferiority are not always imaginary. A patient of mine was told by a classmate, "I'll tell you why you have no friends. It is simple. You are nasty." Another adolescent patient, Mary, complains in the initial interview about "her feelings of inferiority," how she is self-conscious when she enters a bus, and feels as if everybody is staring at her, how she cannot make friends with nice girls, and feels generally unhappy. But, her feelings were not at all irrational. With her bleached hair, crude makeup, hard looks and very poor taste in dressing she looked so vulgar and promiscuous, as to attract attention. If a patient is justly disliked it will not help to reassure the patient that his or her worries are unjustified. One has to influence the patient sufficiently to change his behavior, manner and appearance and then he will find himself liked, and will naturally acquire a better self-esteem. It took me some time to discover that the complaints I heard so frequently from patients about the nagging or interference of their boss or of their frictions with their co-workers were often not paranoid or neurotic, but due to the fact that their performance was poor, and finding fault with others was a form of self-defense. "Supporting" therapy in these cases in trying to make the patient less sensitive to other persons' reactions is not only socially undesirable and unrealistic, but takes away the incentive to change and is clinically harmful.

Painful feelings of anxiety, shame and guilt are pathological only if excessive. They form a necessary part of development, providing useful incentives towards achievement, socialization and self-control. If they are excessive, they interfere

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with normal functioning, as we know; but their lack is equally hampering. By blunting the patient's fear of failure, his sensitivity to other persons' reactions, and guilt over bad behavior, we take away his incentives to struggle, to strive and to change. Most patients suffer from a "weak ego," from lack of perseverance, poor volition, bad judgment, poor self-control and a disturbed sense of reality. These should be corrected, and this cannot be done by taking away the emotions that act as incentives. Our mental faculties and defenses develop largely like our physical functioning, by exercising them, and we only exercise them in situations of challenge. There is, of course, an optimum: excessive demands may dishearten and crush the patient, so that he stops trying, but demands that are too low avoid the need for trying. Therapy and education must be elastic and modify the demands made on the patient according to what he is capable of at the moment. But though they may have to be relaxed temporarily, this does not mean they should be lowered permanently. If a patient is allowed in therapy to let himself go too much, his defenses become weaker, he fails to learn to exercise self-control and judgment, and carrying this over to life situations, he incurs failure and becomes disliked by others, and thus becomes more abnormal and deteriorates.

A similar objection can be made to the attempts of some therapists "to get the aggression out" or to "remove inhibitions." An "analytically oriented" therapist tried to get the patient's aggression out with the result that the friction between her and her sister became unbearable; so he sent the sister to another therapist who practiced a similar method, got the sister's aggression out and then hell really broke loose, with constant scenes and the patient having unbearable anxiety. The therapist also pointed out to her that she should not allow her employer to exploit her, with the result that she gave up the job she had held for thirteen years and which had been the most stabilizing factor in her life. As a result of trying to "remove her inhibitions," she had become promiscuous, lost her self-esteem and felt she had no more chance to get married. She became increasingly disturbed and hostile to the therapist, who in turn became upset and resentful, which made the situation worse, and she was eventually sent to a mental hospital. There she calmed down somewhat but as a result of the insulin treatment she put on thirty pounds and lost her looks; when she came out her sister refused to live with her and the patient could not tolerate living alone; nor was she willing or able to make the effort to get a job.

The aim of treatment must be to change the patient, and we must evaluate realistically what changes should take place. The patient lives in society, has a family, should have friends and a job or get an education; treatment that fails to remedy his inadequacies in these areas or makes them worse is bound to have an ill effect.

While some friendliness or helpfulness on the part of the therapist is desirable, it should be realistically limited. It should not amount to condoning or even encouraging the patient's neurotic or anti-social attitudes. To be able to influence the patient we must in some areas or to some degree go down to the patient's level, show understanding for his abnormality, for the trouble he finds himself in, for the justifications of his resentment. But if we remain on the patient's level we do not change him. We have to reach him in order to move him. Often the kindness as such is not the therapeutically valuable factor but the kindness enables the therapist to gain influence which he then utilizes for therapeutic purposes. Many therapists are afraid to be too critical for fear of antagonizing or losing the patient. Yet, I found that the patient often resents a stand much less than one might expect, provided the results achieved are in his

own interest and the arguments make sense to him. I told Mary that she had cause to worry about her appearance and that she looked vulgar and far too old, that too early promiscuity leaves a mark, and told her how she should dress and make up, but added that she could really look nice, if she tried. After she left I wondered whether I had not gone too far, telling her all this in the first interview, since she had had two years treatment with a very "supportive" caseworker. Then I learned from the new therapist to whom I referred her that Mary came in proudly announcing that she had tried to change her dress and hair style according to my suggestions.

A schizoid patient in his twenties suffering from very severe depression, did nothing for months, and his parents could not move him. When his depression had somewhat improved but his inactivity remained unchanged, I seriously discussed with him the possibility that he may be psychotic and in need of shock treatment. This upset him considerably and the next day he went out and found a job. When I asked him whether he resented that I had frightened him, he thought it over and said, "no, because it worked." He had suffered very much from his inactivity. Patients know when they are a failure and even if they resent being pushed, once they succeed they feel relieved and often grateful. This patient had had years of classical analysis, and his main resentment, mixed with intense guilt towards the therapist, was over the fact that the therapist had been ineffective. Another patient had had four years treatment for exhibitionism, during which time he continued to commit his offenses, was childishly defiant to the doctor, untruthful and irresponsible. I pointed out to the patient in the first interview the seriousness of his legal situation and his general lack of consideration, and added that the last therapist had every reason to be indignant. Yet, I have an excellent relation with the patient. He feels friendly towards me and is sincere and cooperative. It is important to convince the patient that by trying to socialize him we are doing something *for* him, and not against him, and transmit to him the positive value and gratifications of social standards.

Maladjustment is not always due to feelings of inferiority; ideas of grandeur are often more pathogenetic, as they may lead to a psychotic escape from reality and even cause a permanent psychosis. An adolescent boy had had one year of classical analysis, but after an initial improvement became worse. His next therapist was "eclectic," trying to give him "support." The patient had had schizophrenic ideas about time and space, feelings of unreality and ideas of grandeur. He thought he was the greatest poet who ever lived. Yet his therapist told him "do not doubt yourself" and "it is inevitable that you will not be understood," thus taking away the flimsy threads that still held him to reality. When he came to me he was a wild-eyed, deluded schizophrenic, excitedly telling me that he was the greatest genius of all times. One reason why I established a relation with him and normalized him was because I showed him my intellectual superiority, occasionally put him in his place and tended to tease him. His father had never said "No" to him, and tried to eliminate all pressures. The father's weakness was largely responsible for his insecurity, yet the therapist who condoned everything had seemed to him still weaker.

Indiscriminate permissiveness not only appears as weakness to the patient, but often expresses the actual weakness of the therapist. Sometimes he is afraid to antagonize the patient by making a stand; sometimes he is too reluctant to face painful facts himself and, therefore, minimizes them. The therapist should support the patient, when the latter cannot cope with life. But "support" means that the therapist is able to put himself in the pa-

tient's place, sees the world both as the patient sees it, and as it actually is, can identify with the patient's painful state of mind or bad situation and then teach him how to cope adequately both with his own reactions and with other people. This is not tantamount to humoring.

By treating a person too softly we often increase his anxiety because he regards the fact that too far-going exceptions are made for him as an indication that there is something radically wrong with him. Also, a humoring springing from the therapist's inability to tolerate a bad situation or anxiety is often felt by the patient as such, and increases the patient's own oversensitivity. The patient must learn, whether he is told this in so many words or not, that the therapist understands that he suffers from anxiety, depression or humiliation, but that he expects him to tolerate it, and to become less sensitive to it, and that by exposing himself to situations he dreads and coping with them realistically, the anxiety will diminish. I have successfully explained this even to young children, for instance, to a child suffering from a school phobia, and the child felt much happier once she was able to go back to school and behave like her friends.

Pressure does not mean brutality or shouting at a patient. It is creating and utilizing incentives and guiding the patient's reactions into desirable channels. A good personal relationship and the wish to please the therapist is a strong incentive. Therapeutic dependency for a limited period is desirable provided it is utilized for clinically justified aims, and as soon as the patient normalizes he automatically becomes more independent. The therapist must take responsibility. "Permissiveness" is sometimes an excuse to avoid taking responsibility or making decisions; but we are responsible for our omissions as much as for our commissions,[1] and a weak-willed patient with no strong person in his environment will be hurt by identifying with his therapist's indecision and fear of responsibility.

Apart from the therapeutic relation, many positive and negative incentives in the patient's life can be utilized to make him function better and to socialize. Making him aware of achievements as well as failures is useful, as the achievements can be used as positive, and the failures as negative incentives. Even with a normal person who has objective reason to be unhappy, frightened or depressed, too much encouragement or sympathy is often ill-advised as it encourages self-pity and defeatism. They should be given enough sympathy to establish a relationship, which is then used to direct them towards a future or to give them positive aims. The same holds true very much more for maladjusted persons who have serious disturbances of volition, are narcissistically self-centered and lack the wish to change, are unduly afraid of failure and are disturbed in their relation to society and reality. With them it is of paramount importance to develop and utilize incentives and develop identifications with active persons taking initiative and responsibility.

Permissiveness is a therapeutic tool with patients who have been very intimidated. With others it is a means to an end. It helps to establish a relationship that can be used for normalizing and socializing. With a very abnormal or antisocial patient a good deal must be tolerated because he is incapable of living up to normal standards. However, the aim of therapy is not to allow him to remain as he is by making his abnormality acceptable, but by gradually changing him. He should be accepted as a potentially normal, social and responsible person, while initial allowances are made for the fact that he still is not what he should be. Therapy should gradually change him into what he is capable of being.

[1]See the Editorial in the *Psychiatric Quarterly*, April 1958.

Treatment of Headache

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Headache is one of the commonest complaints which the physician is called upon to treat. It is necessary to emphasize that in treating a headache we are dealing with a symptom and not a disease. As an isolated symptom it is not in itself diagnostic of any disorder, but may be associated with a variety of clinical conditions including hypertension, arteriosclerosis, brain tumor, infection, allergy, cranial trauma, and emotional disturbances. As such, headache may be an indication of an underlying disturbance within the cranium, in other systems of the body, personality, environment, or a combination of these factors.

The object of treatment is to alleviate the pain of an immediate attack and to relieve the underlying cause, thereby preventing subsequent attacks. Therapy starts with the prerequisite that the physician be able to diagnose the type of headache with which he is dealing. The diagnosis depends upon the understanding of the physiologic and psychologic mechanisms responsible for pain. A detailed history and thorough examination is essential in order to arrive at conclusions regarding these mechanisms.

The four main methods available for the treatment of headache are pharmacotherapy, psychotherapy, physiotherapy and surgery. Each may be tried individually or in combination. In most instances, pharmacotherapy and psychotherapy are the most effective methods of treatment. Surgery is rarely indicated.

PHARMACOTHERAPY

Although drugs alone may not solve the basic therapeutic problem, they are of considerable value in the treatment of patients with headache. Evaluation of the effectiveness of drugs in patients with chronic headache is a difficult task which requires controlled studies in a large number of patients over a long period of time. In evaluating a drug, it is important to recognize that its efficiency does not depend upon its pharmacologic action alone. The importance of dosage, timing, mode of administration, toleration by the patient, and attitude of the physician to the patient cannot be stressed sufficiently. Furthermore, the drug's efficiency largely depends upon the patient-physician relationship which includes, among other things, the length and frequency of interviews. Our experience indicates that the patient's reaction to drugs may depend not only upon the underlying disorder responsible for the headache, but also upon the degree of incapacity, constitutional make-up of the patient, duration of symptoms, age of individual, and psychologic status. The symbolic effect of taking a prescribed drug is also a contributory factor in treatment. All of this must be given serious consideration in clinical usage of drugs in treatment of headache.[1]

It is important to be aware that the response to a painful sensation is dependent not only on the strength of the stimulus but also on the individual's reaction to pain. The latter is based upon the emotional state and behavior pattern of the individual so that an individual's reaction to pain may be distinct from the sensation he is experiencing. A mild stimulus may cause much suffering because of what it connotes to the patient, whereas a strong stimulus may be well tolerated.

Pharmacological treatment may attempt one or more of the following: (1) to raise the pain threshold; (2) to interrupt the mechanism producing pain; or (3) to re-

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lieve the emotional tension and anxiety associated with the pain. Treatment of headache by chemical agents is a highly individualized matter, and the regimen for each patient varies. For a discussion of the drugs commonly used in the treatment of headache, the reader is referred to our recently published article on the principles of pharmacotherapy.[2]

PSYCHOTHERAPY

Our own clinical studies and those of others have demonstrated that in most patients with chronic headache, psychological factors co-exist with the headache. It is most difficult to verify that in any, or all, of these patients, the primary etiology is psychogenic. However, whether the psychological factors are primary or secondary, psychotherapy in some form is indicated.

To the patient, a symptom related to the head is frequently associated with profound anxiety and apprehension. This is due not only to the underlying emotional conflicts responsible for the headache but also to the threat of the symptom itself, for headache may also represent to the patient a disorder of the brain and may cause a fear of loss of mind or intellectual capacity. Such fears are not without foundation; headache may indeed reflect a disturbance in intellectual functioning when a person is incapable of solving a mental or emotional problem. Furthermore, severe disturbances such as schizophrenia or cerebral arteriosclerosis may be preceded by headache not necessarily related to morphological changes of the brain.[3]

Psychogenic factors produce symptoms in one of two different ways. One way would be due to conversion, in which an emotional conflict is converted into a physical dysfunction. Such conversion phenomena are often understood in terms of their symbolic meaning. To understand the specific meaning of such a symptom, one needs to be familiar with some general principles of dynamic psychopathology, in addition to having specific information about the person with the symptom.

Psychogenic symptoms may also express themselves directly in alteration of specific physiologic functions. These alterations are very often the physiologic expressions of the existing emotional feeling or tension state. Frequently these physiologic alterations are not due to conversion, as it is seen in cases of conversion hysteria where psychic "energy" derived from the repression is "converted" into a physical symptom or sign. In some patients, however, both of these mechanisms can be observed simultaneously.

In the majority of our cases of headache, the precipitating psychic factors were largely unconscious, although most patients were aware of their anxiety. Environmental demands of an economic, social, physical, or intellectual nature beyond the capacity of the patient's personality also have produced headache.

There are many other mental adaptive mechanisms which may play a part in determining why the choice of the symptom is head pain.[4] Among them is "identification" with a family figure which is closely bound with the "introjection." The identification may be positive or negative. If positive, it is based on a wish to be like the other person who is loved or respected, etc. If negative, it is based on hostility with guilt toward the other person and, in some instances, the person assumes those attitudes and characteristics of the other person which produce pain. As an example, one can cite the case of a girl who resented her older sister who had headaches; or the son who has hostility toward his father, and does to himself what he wishes to do to the other person. For these destructive thoughts, self-punishment is based on guilt feelings resulting from hostile feelings toward a loved one.

In other patients, the symptoms may be due to the need for gaining attention or affection. This is frequently seen in persons whose childhood background is one

of over-protection or who only gained love or attention when they were in pain or ill. Identification may also play a role in these patients. In some patients the headache may be due to a need to remain in a position of dependency.

The symptom of headache may occur in persons who had a head injury or illness in which head pain was a prominent component. Memory of such past experiences occurs when similar experiences or situations are encountered or when the emotional status of the patient is one in which pain is utilized to alleviate feelings of hostility associated with guilt.

The therapy of patients with headache requires the understanding of certain pertinent points. The first and most important point is the necessity for an accurate and complete history, which includes the setting in which the symptoms arise in terms of the life history of the patient. During the ordinary history taking and physical examination, it is very necessary to explore the psychic reactions of the patient toward his environment, and to ascertain what kind of emotional conflicts he has. Deep-seated conflicts, of course, cannot be unearthed by this method, and in many instances, a detailed study of the reactive resources of the individual, i.e., his personality, is indicated.

The patient must be given full reign to divulge the relationship between his complaints and the crucial events in his life. Later the material may be arranged in chronological order and the physician may clarify any important gaps which exist in the patient's story. Another important point has to do with the fact that the doctor is cognizant of an interest in the psychologic as well as the physical factors that are implicit in almost every illness. The physician must have some knowledge of the more common psychodynamic factors which produce headache. As the history unfolds, the physician should keep these factors in mind as a sort of framework of reference. Does the symptom result from identification, suppressed or repressed hostility, guilt, self-punishment, or is it an attention gaining device? What are the factors in the present situation which are producing hostility and resentment which the patient is not expressing? In addition, the objectivity of the physician is also dependent to a great extent on his stability and the nature of his own biases, and it must be pointed out that blind spots due to personal experience and the nature of his professional training may hamper or enhance the doctor's capacity to understand his patient.

The most important single factor in the psychotherapeutic process is the emotional relationship of the patient to the physician. This relationship dominates the treatment despite the fact that it may be explicitly discussed only rarely, or not at all. If the patient feels that the physician is really an interested, understanding and sympathetic person, the patient gains confidence in the physician. It is then possible to explore those factors in the patient's present life situation which have led to resentment, hostility, self-punishment, etc. In full-fledged psychoanalysis, this relationship is clearly recognized by the patient and the therapist.

In emphasizing the importance of the physician-patient relationship, one must not, of course, overlook the importance of other aspects of psychotherapeutic procedures, such as environmental manipulation, ventilation of wholly or partly unconscious emotional conflicts by the patient, etc.

In environmental management one has to recognize and deal with the patient's capacity to handle his work, recreation, family and social life. The physician should strive to correct the patient's program so that work, play and rest are balanced. In some cases, a sustained hobby is of value in securing relief from tension and daily stresses. It is important, however, that the doctor assist the patient

in making his own decisions, rather than make the decisions himself.

Often it is more practical and more satisfactory to have the patient adjust to his environment rather than alter the environment. This is done by ventilation—having the patient talk out his problem with the aim of gaining greater understanding of his emotional difficulties. He may thus achieve freedom from needless anxiety, and be enabled in turn to cope with actual stressful situations. The physician must learn to listen patiently and create trust and confidence.

Simple explanations of the effect emotions have on the bodily functions and the relationship of stress situations to development of symptoms may give the patient insight into what occurs to him during periods of stress. Reassurance, suggestion and re-education are other technics which may help the patient gain the necessary security and readjustment.

The therapy suggested is within the province of the interested general practitioner. Under this treatment, over-all improvement can be anticipated, in terms of greater capacity for life adjustment and reduction of the habit patterns which lead to activation of the physiologic mechanism causing the headache. In some patients where reorganization of the personality is necessary to secure relief, formalized psychiatric treatment is necessary. This approach cannot guarantee results, especially with patients who have been sick for a long time, but certainly offers possibility of improvement which may not be achieved by drugs or other forms of therapy alone.

PHYSIOTHERAPY

Sustained contraction of the muscles of the head and neck is frequently a mechanism which produces headache. Treatment of these muscular disorders is based on a variety of physical methods including hydrotherapy, electricity, exercise, massage and mechanical devices such as collars and traction.

In some patients, ethyl chloride spray may be employed to secure relief of muscle spasm and pain. Injection of procaine hydrochloride, 1 to 2 per cent, into tender areas of the neck is helpful temporarily in some headaches associated with discogenic disease, myofibrositis and myalgia of the neck.

SURGERY

The treatment of headache by surgical technics is limited largely to a few specific conditions wherein the operation can be directed toward a primary source. Successful surgical relief of most cephalic pain is limited because the transmission pathways of the pain are uncertain, relief is frequently temporary, pain may occur in another area, and complications are persistent and unpleasant. Section of the trigeminal, glossopharyngeal, greater occipital nerves, and cervical roots should be used only with specific indication of involvement of the nerves thus treated. There are many reports in the literature of operative procedures for various types of vascular headache including migraine. Surgical procedures for migraine and other types of vascular headache are not recommended. In evaluating the reports, it must be remembered that headaches are often improved or eliminated during hospital stay, prolonged convalescence or coincidental reduction of stress and responsibilities without instituting surgery. Furthermore, to the patient with headache, the psychological connotation of having surgery may contribute to the temporary improvement.

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A Study of Deprol — An Effective Antidepressant

CHARLES W. MCCLURE, M.D.

Mental health is obviously a complicated subject, perhaps much more so than is generally believed. Disturbances in it require on our part an understanding of the needs of human personality. It is a compelling challenge concerning which there exists an incomprehensible over simplification. Indeed, only too often have we observed the subject approached as though some simple formula would enable the confused and depressed patient to find a good, healthy, interesting and peaceful life. Obviously, this is the desire of every normal person. However, in this age of political confusion, a space-age world of fission and fusion, of intercontinental missiles and bacteriological warfare, not to mention income taxes, mental disturbances characterized by depression have become serious medical and sociological problems.

In my discussion of our studies of depressed patients and of the role of the drug, Deprol, as a short cut in bringing about relief, I wish to emphasize that I shall not follow the notice displayed in a drugstore window, i.e., "We dispense with accuracy." For the sake of accuracy I may state that I am neither a psychologist nor a psychiatrist, but a gastroenterologist. In my practice the great majority of patients are suffering from more or less serious organic disease. These patients are human beings beset with human problems. It is the latter which are so apt to be neglected in the treatment of the patient, often leaving him in a state of frustration culminating in depression. As one example consider the case of a seventy-one year old man suffering with carcinoma of the urinary bladder. The genitourinary surgeon considered the bladder condition to be satisfactorily controlled and referred the patient because of mild but annoying lower abdominal pain. The patient was markedly depressed and remained so after thorough diagnostic studies disclosed no cause for pain. I then found out that the patient was not concerned about his organic condition. What caused his depression were human problems: how much longer could he work; would he die an incapacitating lingering death; what would become of his wife, etc. The administration of Deprol, together possibly with my interest in his problems, greatly relieved his depression and enhanced his peace of mind.

Patients who are depressed never feel well, regardless of the presence or absence of organic disease; they present complaints relating to any or possibly all organs of the human body. These patients first consult their family doctor. Unfortunately, the family physician is apt to be too busy to go into the problems of depression. As a result patients are treated for headache, constipation, irritable colon, backache, glandular disease, etc. The frequent occurrence of this unsatisfactory situation led us in the Brusch Medical Center to seek means of correcting it. This search in turn led us to a study investigating the action of Deprol, in relieving disturbed and depressed states. For the purpose of the study we established a workshop composed of general practitioners, internists, urologists, surgeons, psychologists, psychiatrists and, when indicated, other specialists of our consulting staff. This organization, together with the comprehensive diagnostic facilities of our Medical Center, is mentioned in order to give some conception of the care and thoroughness with which the study was made.

The patients for this study were partly from our Medical Center and partly referred by their family physician or by Rescue Incorporated. The latter is a non-sectarian group established to aid depressed persons, many with suicidal tendencies. Its headquarters are in the Boston City Hospital.

When a patient came to our workshop he was subjected to organic, psychologic and psychiatric examinations. First a searching history and physical examination were undertaken as leads to possible organic disease; then any further indicated diagnostic procedures were made. The patient was then turned over to the psychiatrist. If the psychiatrist concluded the patient was not mentally de-

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teriorated or not too seriously disturbed or depressed he was sent to the psychologist. The psychological status of the patient was determined; his personality, his acuity of perception, his reactions to his enviroment, and his ability to do for himself, were examined. These examinations showed that the reactions of depressed patients to adversity, such as the death of a loved one, loss of work, marital problems, failure in school, the presence of organic disease did not follow a normal pattern but had become exaggerated and prolonged. In other words, the stresses of life had caught up with them, and usually produced three fundamental etiological factors: bitterness, anger, or frustration.

While our patients usually did not say they were sad, they often complained of being "low, miserable, and feeling horrible." Many appeared to be careworn, assumed a somewhat stooping posture and showed loss of weight. The handshake was weak and they showed other symptoms of lowered vitality. Insomnia was frequent, explaining in part the constant sense of fatigue which was worse in the morning or upon arising than when the patient retired. Mental lethargy was reflected in inability to concentrate, in confused thinking, in inability to plan or make even trifling decisions, slowed speech and in a general lack of interest in affairs that were once zestful. Such symptoms were frequently terrifying to the patient and at times caused him to fear the onset of insanity. Noteworthy was the marked tendency to brood and ruminate upon shortcomings and to assume an attitude of hopelessness and inadequacy. Also common were a variety of gastrointestinal symptoms.

For the study of the role of Deprol in depression every safeguard was considered to insure against misinterpretation of the results obtained. It is so easy to draw conclusions from clinical observations which appear to be logical, but are actually spurious. This was prevented by employing three fundamental safeguarding procedures: 1) each patient was studied organically, psychologically and psychiatrically, as already discussed; 2) the placebo method was employed, and 3) scrutinizing observations of the patients' progress were made. They were divided into two groups of 64 each. One group was given placebos for 21 days and the other group Deprol. At the end of the 21 days the placebo group had seven cases partially recovered while in the Deprol group 33 were partially or completely recovered.

Then the cross-over technique was employed. Members of the Deprol group were given the placebo and after 10 days this group began to relapse into the previous state of depression. Those in the placebo group were given Deprol and after ten days a full third of them had made considerable improvement. At this point all the patients were placed on Deprol.

As a result of the administration of Deprol about 77% of the entire group of 128 patients recovered over a period of between three and eight weeks. The remaining patients showed either no improvement or became progressively worse.

Our findings fully justify the conclusion that Deprol is an efficient aid in the relief of depressions.

When a man is well, he is well in mind and body. When he is sick, he is more likely to be sick in mind and body, too. The physician experienced in the psychosomatic approach, therefore, sets out to treat patients as complete human beings.

Flanders Dunbar, M.D.

Psychodynamics and Psychotherapy of Depression

JOHN M. MACKENZIE, M.D.

Any comprehensive review of the literature of depressions would consume more time than was allotted to the panel. Allow me then to choose some personal highlights to establish my thesis for treatment. René Spitz, describing the reaction to abandonment of infants in foundling homes, found a rather typical reaction which he labeled "anaclitic depression," the earliest form of depression. He, with Margaret Ribble, established the absolute necessity for psychological contact as well as psychological supplies. All those attitudes are grouped under the term mothering: contact, warmth, massage and simple early communication. The child's reaction is the earliest expression of the depression. John Bowlby, observing children from the ages twelve to thirty-six months, described devastating effects when these children were separated from their parents.

Freud, in *Mourning and Melancholia,* showed the relationship between normal mourning and melancholia. Mourning has been elaborated from the clinical experience of the Cocoanut Grove fire and World War II by Erich Lindemann. He postulated the stages of grief, wherein the defensive stages of normal grief are denial, projection, distortion, self-blame, demand, anhedonia with the reinvestment of interest in new objects.

These represent the early normal reactions to real or fantasied losses; they are loss of supplies. In more adult terms, these could be translated into terms of things that give a person self-esteem, self-respect, attention, love, appreciation, etc. The psychological exposition of the concept of self-esteem was given by Edward Bibring—"Depression can be defined as the emotional expression (indication) of a state of helplessness and powerlessness[5] of the ego, irrespective of what may have caused the breakdown of the mechanisms which established his self-esteem." The feelings of helplessness are not the only characteristic of depression. On further analysis, one invariably finds the condition that certain narcissistically significant, i.e., for the self-esteem pertinent, goals and objects are strongly maintained. Irrespective of their unconscious implications, one may roughly distinguish between three groups of such persisting aspirations of the person: 1) the wish to be worthy, to be loved, to be appreciated, not to be inferior or unworthy; 2) the wish to be strong, superior, great, secure, not to be weak and insecure; and 3) the wish to be good, to be loving, not to be aggressive, hateful and destructive. It is exactly from the tension between these highly charged narcissistic aspirations on the one hand, and the ego's acute awareness of its (real and imaginary) helplessness and incapacity to live up to them on the other hand, that depression results.

In the first group the depression sets in whenever the fear of being inferior or defective seems to come true, whenever and in whatever way the person comes to feel that all effort was in vain, that he is definitely doomed to be a "failure." In the second group of persisting tensions (schematically described as the desire to be strong), the depression is due to the shocklike (actual or imaginary or symbolic) evidence that this goal will never be achieved due to the ego's weakness, that one is doomed to be a "victim" (with regard to dangers, or merciless powers and their unconscious implications). In the third group of tensions (the desire to

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be loving, not to be aggressive, etc.), the narcissistic shock (blow to the self-esteem) is due to the unexpected awareness of the existence of latent aggressive tendencies within the self, with all the consequences involved, and this in spite of the fact that one had tried hard to be loving and not to hate, not to be "evil."

These three sets of conditions are, of course not exclusive of each other but may, under certain circumstances, coexist in varying combinations in the same individual and at the same time. Though the persisting aspirations are of a threefold nature, the *basic mechanisms of the resulting depression appears to be essentially the same.* According to this view, depression is primarily not determined by a conflict between the ego on the one hand and the id, or the superego, or the environment on the other hand, but stems primarily from a tension within the ego itself; from an inner-systemic "conflict." Thus depression can be defined as the emotional correlate of a partial or complete collapse of the self-esteem of the ego, since it feels unable to live up to its aspirations (ego ideal, superego) while they are strongly maintained.

One could ask at this point whether the simple, i.e., uncomplicated grief reaction fits in the proposed scheme. In the instance of an actual loss of love object, the resulting tension can be described as a longing for the lost object and love, and a wish to retrieve the loss (maintenance of object and goal). The depression, sometimes accompanied by a feeling of pain, appears to derive from the fact that here too the ego is confronted with an inescapable situation, since it does not have the power to undo the loss. Observation shows, e.g., that an exacerbation of the grief reaction occurs whenever certain conditions bring the loss and the inability to retrieve it acutely into awareness.

Accordingly, basic depression represents a state of the ego whose main characteristics are a decrease of self-esteem, a more or less intense state of helplessness, a more or less intensive and extensive inhibition of functions, and a more or less intensely felt particular emotion; in other words, depression represents an affective state, which indicates a state of the ego in terms of helplessness and inhibition functions.

Summarizing, one can say that there are four basic ego states: 1) the state of balanced narcissism (normal self-esteem), the secure and self-assured ego; 2) the state of excited or exhilarated self-esteem, the triumphant or elated ego; 3) the state of threatened narcissism, the anxious ego; and 4) the state of broken down self-regard, the "inhibited" or paralyzed, the depressed ego. In other words, depression is on the same plane as anxiety and other reactive ego states. It is essentially, "a human way of reacting to frustration and misery" whenever the ego finds itself in a state of (real or imaginary) helplessness against "overwhelming odds."

The orally dependent type which constantly needs "narcissistic supplies" from outside, represents perhaps the most frequent type of predisposition to depression, which is not surprising if one takes into consideration the fact that the infant has actually no power over its objects and the necessary supplies it has to receive from them, that it is entirely dependent on the benevolence of the environment for the gratification of its needs and maintenance of its life. Frequent frustrations of the infant's oral needs may mobilize at first anxiety and anger. If frustration is continued, however, in disregard of the signals produced by the infant, the anger will be replaced by feelings of exhaustion, of helplessness and depression. This early self-experience of the infantile ego's helplessness, of its lack of power to provide the vital supplies, is probably the most frequent factor predisposing to depression. I should like to stress the point that the emphasis is not on the oral frustration and subsequent oral fixation, but on

the infant's or little child's shocklike experience of and fixation to the feeling of helplessness.

A strikingly different picture is offered by the anal-sadistic phase. In contrast to the child on the oral level, the child of the anal phase has often to defend certain of his strivings and cherished sources of gratification against the interference by the objects. The oral child is completely dependent on the objects; it is therefore easily made to feel helpless. The child of the anal phase usually has acquired a certain independent ego strength, a certain capacity to control his body and his instinctual interests as well as the objects. It has learned not only how to exert sphincter control but is also capable of saying no, of defying grownups, of mobilizing various forms of aggression as a defense against the interfering objects. The narcissistic aspirations characteristic of this phase refer to mastery over the body as well as over the drives and the objects. When in reaction to the sometimes intense aggression, feelings of remorse and guilt are developed, together with a fear of punishment, the corresponding aspirations will consist of the wish to be good, not to be resentful, hostile, defiant, but to be loving; not to be dirty, but to be clean, etc. Depression, i.e., the feeling of relative powerlessness or helplessness, will refer to the lack of control over the libidinal as well as aggressive impulses or over the objects, to the feelings of weakness (I am too weak ever to control the forbidden impulses or the interfering objects), or to the feelings of guilt (I shall never succeed in being good and loving, I am destined to be hateful, hostile and defiant, and therefore evil).

The phallic phase shows again a different type of ego involvement. Competitive strivings within the oedipal situation are intimately linked up with exhibitionistic and sadistic needs to defeat the rival and to be admired by maternal images or substitutes. In the phallic stage, therefore, the narcissistic aspirations stem mainly from the competitive situation, the wish to be admired, to be center of attention, to be strong and victorious, not to be defeated, and so forth. Depression may result, e.g., when the fear of being defeated and ridiculed for one's shortcomings and defects, or the fear of retaliation, etc., seem to come true and the ego proves too weak to prevent the inevitable.

To summarize: what has been described as the basic mechanism of depression, the ego's shocking awareness of its helplessness in regard to its aspirations, is assumed to represent the core of normal neurotic and also psychotic depression. It is further assumed on the basis of clinical material that such traumatic experiences usually occur in early childhood and establish a fixation of the ego to the state of helplessness. This state is later regressively reactivated whenever situations arise which resemble the primary shock condition, i.e., when for external or internal reasons those particular functions which serve the fulfillment of the important aspiration, prove to be inadequate.

It is finally assumed that all other factors which determine the different clinical pictures of depression represent accelerating conditions or "complications" superimposed on the basic mechanism by the oral defense mechanisms and their sequelae.

To discuss these points briefly:

1) *Depression represents a basic reaction* to situations of narcissistic frustration which to prevent appears to be beyond the power of the ego, just as anxiety represents a basic reaction of the ego to situations of danger. Depression is defined as being primarily an ego phenomenon, i.e., as being essentially independent of the vicissitudes of aggression as well as of oral drives. Since depressions frequently appear to be linked up with self-reproaches, the concept of depression became synonymous with self-accusation

and self-destruction to such a degree that nearly every depression was viewed as resulting from the turning of originally object-directed aggression against self. The same holds true of the relation between depression and oral implications in depression which led to the definition of the predisposition to depression in terms of oral fixation. It is true that an orally oriented person, who is dependent on external "supplies" for the maintenance of his self-esteem, is prone to narcissistic injuries and oral recovery mechanisms, but to reverse this statement is not justified.

It should be stressed that the conception of depression presented here does not invalidate the accepted theories of the role which orality and aggression play in the various types of depression. It implies, however, that the oral and aggressive strivings are not as universal in depression as is generally assumed and that consequently the theories built on them do not offer sufficient explanation, but require a certain modification; it is our contention, based on clinical observation, that it is the ego's awareness of its helplessness which in certain cases forces it to turn the aggression from the object against the self, thus aggravating and complicating the structure of depression.

2) In general, one may say that everything that lowers or paralyzes the ego's self-esteem without changing the narcissistically important aims represents a condition of depression. External or internal, actual or symbolic factors may consciously or unconsciously refute the denial of weakness or defeat or danger, may dispel systems of self-deception, may destroy hope, may reveal lack of affection or respect or prove the existence in oneself of undesirable impulses or thoughts or attitudes, or offer evidence that dormant or neutralized fears are actually justified, and so forth. The subsequent results will be the same: the individual will regressively react with the feeling of powerlessness and helplessness with regard to his loneliness, isolation, weakness, inferiority, evilness or guilt. Whatever the external or internal objects or representations of the narcissistically important strivings may be, the mechanism of depression will be the same. The narcissistic shock may be mild or severe, focal or extensive, partial or complete, depending on whatever peripheral or central narcissistic aspirations are involved. These factors will contribute to the extent and intensity of the depression as well as the possibilities, the means, or the tempo of recovery.

Our scheme seems not only suitable to bring a certain order into the variety of configurations resulting in depression, but also permits a clearer conception of the therapeutic effort. From a theoretical as well as therapeutic point of view one has to pay attention not only to the dynamic and genetic basis of the persisting narcissistic aspirations, the frustrations of which the ego cannot tolerate, but also the dynamic and genetic conditions which forced the infantile ego to become fixated to feelings of helplessness. Its major importance in the therapy of depression is obvious.

3) The same conditions that bring about depression, when reversed serve to alleviate the depression. Generally one can say that depression subsides either a) when the narcissistically important goals and objects appear to be again within reach (which is frequently followed by a temporary elation), or b) when they become sufficiently modified or reduced to become realizable; or c) when they are altogether relinquished; or d) when the ego recovers from the narcissistic shock by regaining its self-esteem with the help of various recovery mechanisms (with or without any change of object and goal). Finally, e) defense can be directed also against the affect of depression as such. This usually results in apathy or hypomania. Certain observations suggest that apathy is due to a "blocking" of the depressive emotion, to the mechanism of de-

personalization in a (usually chronically) depressed person; whereas certain types of hypomania represent a reaction formation to depression, usually combined with a denial of the causes of depression.

4) The most frequent complication of the basic structure of depression can be found in the large group of orally dependent people who thrive on "oral-narcissistic supplies" and collapse when these are lacking, or who in reaction to severe frustration regress to the oral mechanism of restitution, the most fateful recovery mechanism consisting in the incorporation of the objects in cases of severely ambivalent attitudes toward it.

The correlation between depression and aggression on the one hand, mania and aggression on the other, can be observed in the fantasies as well as in the occasional acting out of depressive patients. On recovery from depression by regaining self-esteem and the feeling of strength, aggressive impulses are released and directed against the object world. Under such conditions, e.g., a female patient frequently had the fantasy of walking along the street, with a large sword in her hand and cutting off the heads of the people passing by to the right and left. The sequence of depression, self-accusation, hypomania, aggression against the outside world, could be clearly observed in the patient. But as much as her aggressive fantasies were secondary to her exaggerated self-esteem, so was the turning of aggression against the self—particularly in form of self-hatred— secondary to the lowering of self-esteem. On the basis of similar observations it seems justified to generalize that the turning of aggressive impulses against the self is secondary to a breakdown of the self-esteem. It is ultimately due to the feeling of powerlessness and helplessness (often combined with masochistic tendencies) that the ego surrenders to the superego and accepts punishment. We observe at least in certain instances the opposite tendencies of the ego, namely, to defy and repress the demands of the superego as long as the ego feels strong and powerful in its rebellion. There are cases where no feeling of guilt and no self-accusation developed (though one would normally expect it) because the bad deed was to a high degree narcissistically gratifying, whereas guilt and self-reproaches develop when the gratification subsides. However, there are depressions which are not accompanied by any self-aggression and there are cases of angry self-hatred which do not show any manifest signs of depression and which are not the result of a defensive action but demonstrate rather a hostile non-identification with or rejection of a given weakness of the self. Such persons hate or resent certain features in themselves in the same way as they hate or resent the same traits in another person. Finally, there is a decisive difference between the "ego killing itself" and the "ego letting itself die." Only in the first case aggression is involved. Giving up the struggle because one is tired and feels helpless is not identical with self-destruction.

5) It is hardly necessary to discuss the conscious and unconscious secondary gains which many patients derive from a depression. This may proceed on the external as well as internal level. By demonstrating their sufferings they try to obtain the "narcissistic supplies" which they need, or they may exploit the depression for the justification of the various aggressive impulses toward external objects, thus closing the vicious circle.

Depression can be said to be a loss of self-esteem. The depressed patient works on the formula of, "I have lost everything and now the world is empty." To understand this, one recapitulates the early develoment of the archaic ego. The infant possesses two feelings which appear to be uppermost; they are hunger and satiation. When the infant is hungry, he cries and moves his body until fed. He then thinks

he is omnipotent. Later, the infant loses his belief in his own omnipotence and tries to regain it through identification with the now omnipotent parents. He participates in this maneuver by being loved. Still later the child may feel alone, deserted, and he experiences a new emotion of depreciation. When the love is returned, self-esteem is returned with it. In the depressed patient, the need to have constant reassurance that he is loved is accomplished by introjection of the dead or missing person. The depression becomes more complicated and more pathological if the relationship to the introjected love object was an ambivalent one to begin with. When this happens, the process of introjection is sadistically colored. The incorporation of the object not only represents an attempt to preserve the loved object but also an attempt to destroy the hated object. In summary, the pathological depression is characterized by an ambivalent introjection of the lost object and a continuation toward the introjected object of feelings that once had been directed toward the external object. With all this, there is participation of guilt feelings throughout the process.

Introjection and denial are extremely difficult defenses to maintain by themselves and in many patients one sees that these defenses are supported by projection as a defense against acting out the ambivalent feelings against the introjected objects resulting in suicide. From our experience in group therapy and that of others (Taylor and Rey) a technique of fostering projection in the treatment of depressions was developed. This was called the scapegoat technique, the object of the therapy is to reestablish the projection of the destructive instincts to the outside world. Since the personality of the suicidal patients has its roots in the early personality development, to use as a scapegoat, figures who are emotionally close to the individual is too fraught with danger. Therefore,, in the initial interview, one looks very carefully for a person who will serve as a scapegoat, against whom the patient can safely direct hostility with the therapist's permission.

CASE HISTORY

A 31-year-old Syrian woman was referred to me from the Casualty Department of the General Hospital where she had been treated for an overdose of barbiturates taken in a serious suicidal attempt. Both she and her husband refused hospitalization but agreed to psychiatric consultation. The pertinent history from the initial interview showed that she had been married for three years to an American, also of Syrian extraction, who was a successful lawyer. They had one child, a boy not quite a year old. They lived in a community, predominantly Syrian, that maintained the Church and many of the customs of Syria. The patient was born and educated entirely in American schools and colleges. The marriage to all outward appearances had been quite happy from both points of view and there wasn't any difficulty with the child. The patient's initial statement was that she felt hopeless and unable to carry on. On further questioning, she stated this had been an increasing feeling and that she had never recovered her strength since the birth of the child. During the initial interview, interspersed with the factual material obtained, there were many doubts expressed about her coming to see a psychiatrist in relation to her condition and subsequent questioning as to whether she was the worst case that I had ever seen. Also during this interview there were numerous references to her relationship with her husband, father, mother and four sisters. These relationships, being too emotionally charged for her, were felt to be too explosive to exploit further. However, in the middle of the interview she again mentioned her doubts about coming to see a psychiatrist and said she had called her obstetrician before coming. He had seen her in the Casualty Department had told her that her suicidal attempt was foolish, and that she should get hold of herself, that she was extremely well situated and she should appreciate her position. When she called again, he repeated this. She mentioned that she had an appointment to see a psychiatrist. His comment was, "If you want to go to one of those blood suckers, go ahead. He will keep you until all your money is gone then send you back to me and I will tell you exactly what I have just told you." She asked what I thought of this statement. Her statement at this time and its implications of devaluating of the therapist indicated that her feelings towards the

obstetrician were of a hostile nature and could be exploited. My comment was that I thought he was stupid and had no understanding of her present condition. This doctor proved to be the perfect "scapegoat" as this was the same opinion she held. Then it came out that she had been brought up in a restrictive community which had been responsible for her almost total ignorance of sexual matters. She had adopted an attitude of pseudosophistication which had added further to her ignorance and brought her to marriage extremely naive and ignorant of sex and reproductive facts. During her pregnancy she had repeatedly tried to ask her doctor for enlightenment. In the later stages when she had been troubled by "monster fantasies" and fears of what was happening to her, he would reply by reassuring her this was a natural process everybody went through, and that there were no difficulties. At the time of her delivery her fears were further heightened when she developed a persistent posterior which was not "natural" and extremely painful. She was in labor 14 hours. Since the birth of the child, her resentment increased when she felt she had been ignored and her husband lauded because of the importance of a son in this community. Many other factors in this girl's background and history contributed to her feelings of hopelessness and her ultimate attempted suicide. The important aspect is the doctor on whom she was given permission to ventilate and again externalize her aggressive feelings.

This was the emergency therapy; gradually her investigation of her feelings shifted to her husband. He appeared to be a very demanding man who wanted the "best of two worlds." His attitude to his work was American, his attitude to his wife Syrian. He was very strict and demanded absolute obedience, particularly in the matter of food. She had to be present and prompt for every meal, and he had definite opinions as to how things were prepared. He likes his tomatoes cut in sections, not sliced. As the patient realized that many of these demands were unreasonable and not due to her inefficiency she was able to retaliate. In fact, she dumped a plate of sliced tomatoes over his head when he complained. Further working with her relationships with her family brought out the conflict of her perfectionistic attitude and their implied criticism which produced her feelings of hopelessness.

In this case the scapegoat technique was used initially to externalize the aggressive feelings of the ambivalent introject to eliminate the self-destructive attitude. Subsequent work was to reduce and modify the narcissistically important goals and objects so they again became realizable.

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It is this very school of psychoanalysis which after laying the theoretical foundation for the work, yet shrinks—with individual exception—from applying that theory to the treatment of organic disease.

"Exploring the Unconscious" by Georg Groddeck.

The Treatment of the Patient with Functional Gastrointestinal Disease

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The treatment of the patient with functional gastrointestinal disease is really the practice of psychiatry. For the most part however, it is psychiatry practiced by non-psychiatrists to whose lot most of these patients fall. The approach to the individual patient must be geared to the insight and limitations of the physician as well as to the physician's estimate of the patient's response to his attitudes and suggestions. The following remarks concern rules of thumb which have proved helpful in dealing with this type of problem.

THE INITIAL CONSULTATION

The most important initial step is to convey to the patient the conviction that at last he has found a physician who will give his undivided attention to the problem and show a sustained interest in its solution. Physicians can learn something from lawyers in this regard, for lawyers concern themselves with problems, and are less likely than physicians to be content with eradicating an annoying symptom. A wise physician once advised me to let the patient talk spontaneously at the beginning of the first interview and not to interrupt him until he stopped. This once cost me two hours, with the result that the physical examination was put off until another day—but it pays. It is likewise important to find out why the patient has consulted the physician: not merely the name of the referring doctor, but the relationship to the former, satisfied patient who initiated the referral; the relative whose recent death from cancer precipitated anxiety over the symptoms; or the reason for consulting the doctor now rather than fifteen or thirty years ago. The physician must learn the art of seeming unhurried. He should plan his schedule so that he actually has adequate time for a thorough interview; lacking this, he can sometimes make a few remarks which will reassure the patient about his sympathy and interest until a longer appointment can be arranged on another day. In the hospital it is a good plan to sit down. Shifting from one foot to the other at the foot of the bed only conveys restlessness, haste, and impatience. The physician should learn to listen with warmth and interest, but never to reveal surprise and almost never an attitude of judgment.

After the history and examination have been conducted, the physician is confronted with the necessity for telling the patient something. The end of the first interview is often one of the most important occasions in the relationship between a physician and patient. It is a time which is heavily loaded emotionally and one in which the patient expects the oracle to speak. An excellent technique on many occasions is to tell the patient exactly what one thinks and even to predict the outcome of the laboratory tests and X-rays which may be undertaken. I often tell the patient what I believe the nature of the problem to be and ask him how he would suggest approaching it. This removes me a little from the paternal role and tends to avoid a relationship of undue dependency upon my decisions. The patient may want to have X-rays in the hospital, or X-rays in a radiologist's office, or defer the X-rays until after his vacation. He may decide that what he needs is a psychiatrist. If his choice is a reasonable one, I go along with it.

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Presented at the Sixth Annual Meeting of the Academy of Psychosomatic Medicine, in Cleveland, Ohio.

Once the diagnosis has been reached, the physician should be quite frank in discussing what the patient has a right to expect in terms of prognosis and relief from therapy. It should be made clear, for example, that with irritable stomachs and irritable colons, one can carry rest and dietary extremes to the point where the treatment is worse than the disease. It is reasonable to point out that intensive psychotherapy, such as psychoanalysis, is quite impractical for an otherwise well adjusted fifty year old patient suffering from one or two mild phobias. It is never wise to impute symptoms to "imagination" or to state that the trouble is "all in your head." Patients readily understand such terms as "tenseness" and "emotional stress." They often can recognize that symptoms occur in association with such tensions even though the meaning of the symptom or its mechanism remains obscure. The physician can place himself in a very strong position with the patient if he can convey the idea that he really understands the misery the patient is experiencing. Dr. Perry McNeill, of Philadelphia, has had a wide experience with migraine. He has stated that one of his most effective therapeutic tools is his ability to convey to the patients the idea that he knows exactly what they are experiencing. Sometimes one can do this by filling in to the patient some of the common characteristics of his syndrome which were omitted in the original history.

The non-psychiatric physician differs from the psychoanalyst in that he is not attempting to cure neuroses. He is teaching patients to live with them. The association between the patient and the physician is likely to be a long one. It is desirable that it not be one of undue dependency on the part of the patient. If the physician makes decisions, particularly in social and emotional spheres, the patient is likely to project upon him the responsibility for his own subsequent failures. The physician avoids this pitfall and also contributes to the independence of the patient by supplying background material, and at times emotional support on the basis of which the patient can make his own decisions.

There is often an element of denouement at the end of the first interview. The physician may think that he has sized up the reason for the consultation and work out the showmanship of the diagnosis and anticipated prolonged therapy only to have the patient say, "Gee, Doc, I figured it was just nerves. My brother died of cancer three months ago. How about my coming in for a check-up next year?"

DIAGNOSIS

With patients having functional disturbances of the gastrointestinal tract it is necessary, at least in one's mind, to make two diagnoses, one concerning the mental state and the other descriptive of the gastrointestinal dysfunction.

The more common gastrointestinal disturbances which are seen in association with nervous tension have been described in the literature at some length. Cardiospasm, peptic ulcer, and ulcerative colitis are organic diseases. However, irritability of the stomach and irritability of the colon are usually purely functional disorders. Whatever psychiatric measures may be employed, cardiospasm usually requires dilation, peptic ulcer diet; ulcerative colitis more or less specific medication. Many patients with peptic ulcer have what the psychoanalysts would designate a character neurosis, with an outward aggressiveness compensating for inner dependency. As a rule such patients lack manifest anxiety, phobias, depression and similar symptoms of psychoneurosis. I have as a rule had poor success in altering their outlook on life and for the most part have had to be content with an autocratic disciplinary approach toward regular meals, smoking, rest, recreation and medications.

With the other groups, the psychiatric

appraisal is important. One sees an occasional compensated schizophrenic. With these it is usually wise to disturb the emotional adjustment as little as possible and proceed at the level of symptomatic therapy. Aside from nausea and vomiting, and very rarely bizarre abdominal pains, conversion hysteria seems to spare the gastrointestinal tract. The conversion symptom usually displaces anxiety, so that there is not enough tension to produce irritability of the stomach or colon.

Most patients with functional gastrointestinal disorders fall into a category with more or less chronic anxiety. Many have an obsessive compulsive make-up, and one not infrequently sees evidence of cyclic depressions, presumably of the psychoneurotic or reactive type. One often sees male or female patients in middle life who have anxiety or depression associated with the overturn in values which takes place at this time—so called menopausal symptoms. Youngsters, in the storm and stress of adolescence, occasionally turn-up.

TREATMENT

In the therapeutic approach to patients with functional disturbances of the gastrointestinal tract, a plausible explanation is often helpful, even if it is incomplete or inaccurate. An explanation of the functions of the autonomic nervous system may be worth while. The observation that cyclic depressions, like thunderstorms, eventually stop, may prove reassuring. The person of obsessive-compulsive make-up may be able to understand why a dog makes a complete circle before lying down in an open field. Patients with mid-life anxiety may be able to see that they are panicked by loss of control of their children, fat, arteries, husbands, or occupational adjustment. They have to learn to close the door on the dirty cellar and let the mess remain.

Patients always feel that they are ready for the death of a parent. The death may not be experienced by outward grief but as a "pull" which shows up in irritability, anxiety, or in a gastrointestinal disturbance. Frequently it takes very little conversation to bring the patient to this degree of insight, and when he knows that grief would pass, he realizes too that the symptom will not last forever.

There are numerous rules of daily living which anyone can employ in helping patients over the bumps of life: "Live life in day-tight compartments;" "Don't cross that bridge till you get to it;" and "Don't cry over spilled milk." Terhune has made a great point of the value of work, play, rest, and exercise every day. The normal rhythm of activities helps. With anxiety and neurasthenia exercise helps the most. It hardens the muscles and apparently raises the threshold to development of symptoms. Conversely, rest, beyond a normal amount, tends to lead to a vicious cycle of fatigue, rest, and more fatigue. Of all forms of exercise, walking is the best. Golf has the advantage of enabling one to take out aggressions on an inanimate ball.

Red Flags

There are situations which arise in the office interview, aside from signs and symptoms *per se,* which indicate to the physician that he is undertaking his therapeutic approach under a handicap. Such situations include the adult patient who comes to the office with his or her mother; the married man or woman who is bringing up his or her family in mother's house; the spinster caring for the chronically ill parent; the patient with the long written list of complaints; the patient with obvious tics; and the woman who says her husband is "such a good man."

Referral to a Psychiatrist

Most of the patients with functional gastrointestinal disorders do better with a psychiatrically oriented internist than in formal psychotherapy. In fact when referred to psychiatrists, they usually bounce and are likely to say—"Well, Doctor, you understand my situation better

than he does." However, there are several groups of patients with whom the psychiatrist does better than the internist. As a rule psychiatrists do better with psychotic patients, especially those having depressions which require shock therapy and schizophrenics on the borderline of compensation. Moreover, the internist should be ever on the alert for the patient with unusual psychological assets which make for the possibility of real psychotherapeutic progress. It is hard to define these people, but usually they are intelligent and are handicapped in some phases of adult life while outstandingly successful in others.

Contrariwise, it is usually a waste of time to refer to psychiatrists compensated simple schizophrenics who are getting by in the community, hypochondriacs, severe obsessive-compulsives, and most patients with mild phobias or neurasthenia.

SUMMARY AND CONCLUSIONS

In the treatment of patients with functional disorders of the gastrointestinal tract, it is important to understand both the nature of the physical disturbance and the emotional make up. The atmosphere prevailing at the initial interview is important because it may determine the relation between the physician and the patient throughout the later phases of diagnosis and treatment.

Most of the patients with irritability of the stomach or colon tend to have some degree of chronic anxiety and tension, often associated with obsessive-compulsive features or recurrent psychoneurotic depressive tendencies. A friendly direct approach to the problem is often rewarding. Plausible explanations are a help for the non-psychiatric physician, who can also utilize reassurance, rules of daily living, and to a limited extent, insight therapy. Patients with frank psychoses should be referred to psychiatrists as should those with psychological assets which might make intensive psychotherapy promising in terms of real progress in the direction of greater maturity in adult life.

Notes and Comments

The 1960 Academy Meeting

The program for the 1960 Academy meeting has been completed. Members and current subscribers will find a copy enclosed with their journals.

Discussion Groups

One of the features of the 1960 meeting will be the inauguration of a new concept in postgraduate teaching. The first two hundred registrants will be divided into groups of ten, and each group will meet for 90 minutes, from 10:30 to 12:00 noon each day, with one of the following moderators: Dr. George Train, Dr. Martin Symonds, Dr. Albert Deutsch, Dr. Harry Sterling, Dr. Joseph Zimmerman, Dr. Harold Berson, Dr. Raymond Nadel, Dr. Harry Perlowitz, Dr. Edward Pinney, Dr. Lionel Blackman, Dr. Murray Lieberman, Dr. Morton Hand, Dr. Abraham Beacher, Dr. Morris Riemer, Dr. Harry Phillips, Dr. William Sheeley, Dr. Murray Peshkin, Dr. Bertram Moss, Dr. Arthur Foxe, Dr. Robert Rutherford, Dr. George Sutherland, Dr. William Kroger, Dr. Victor Szyrynski, Dr. Theodore Rothman, Dr. Jason Miller, and Dr. Leo Wollman.

A coupon for registration can be found on the last page of the journal. Send it in to Dr. Maury Sanger, 1601 Ditmas Ave., Brooklyn 26, N. Y.

Reservations

Hotel reservations for the 1960 meeting may be made by writing directly to the Benjamin Franklin Hotel in Philadelphia. Advance registration will guarantee rooms at the headquarters hotel where all sessions will take place, October 13 to 15, 1960.

Please contact Dr. Bertram B. Moss, arrangements chairman, for reservations for luncheons and banquet. Early registration will guarantee you a place at the particular luncheons you want to attend.

Psychosomatics Editorial Board

In the last issue of Psychosomatics we introduced a few of its editors. Continuing in this vein let us present a few more of the men whose editorial efforts make the journal possible.

Dr. Maury D. Sanger of Brooklyn, N. Y., is Assistant Clinical Professor of Allergy (Pediatrics) at Albert Einstein College of Medicine as well as Attending Allergist, Veterans Administration, Brooklyn, N. Y.; Associate Attending Allergist, Bronx Municipal Center and Allergy Clinic, Mt. Sinai Hospital, New York; and Regional Consultant for the Jewish Home for Asthmatic Children, Denver, Colorado. He is a Fellow of the American College of Allergy, Past President of the Section on Allergy of the Kings County Medical Society, and a Member of the Executive Board of the New York Allergy Society. Dr. Sanger is a frequent contributor to the medical literature on problems in allergy and dermatology with emphasis placed on their psychosomatic aspects.

*

Dr. James L. McCartney of Garden City, N. Y., is a Qualified Psychiatrist and a Diplomate of the American Board of Medical Hypnosis. He is a Life Fellow of the American College of Physicians and the American Psychiatric Association, as well as being a Fellow or Member of numerous other societies. He was the founder and first president of the Nassau (N. Y.) Neuropsychiatric Society and has held several offices in the American Psychiatric Association. He began general practice in China but has been specializing in psychiatry for the last thirty-six years. Formerly, he was Director of the Bureau of Mental Hygiene for the State of Connecticut, and then Director of Classification for the New York State Department of Correction. During World War II, he served with the U. S. Navy in the South Pacific as Chief of the Psychiatric Service, Base Hospital 19. Since the war, he has been in private practice on Long Island and has been psychiatric consultant to the Nassau County District Attorney and the Children's Court. He is the author of *Classification of Prisoners, The Drama of Sex, Frustrated Martyr,* and *Understanding Human Behavior,* and he has contributed several hundred articles to the medical literature.

*

Dr. Victor Szyrynski of Ottawa, Canada, is Professor of Psychotherapy and Associate Professor of Psychiatry at the University of Ottawa. He holds the degrees of both Doctor of Medicine and Doctor of Philosophy, and the qualifications of Specialist in Neurology and Specialist in Psychiatry from the Royal College of Physicians and Surgeons of Canada. He is a fellow of the British Psychological Society of London, the Royal College of Physicians and Surgeons of Canada, the American College of Physicians, and the American Psychiatric Association. During the past ten years his positions in Ottawa hospitals have included Neurologist and Psychiatrist to the Civic Hospital; senior consultant in psychiatry to the R.C.A.F. Rockliffe Hospital; consultant in neurology to the D. V. A.; consultant neuropsychiatrist at the St. Louis Marie de Montfort Hospital; and consultant psychiatrist to the Catholic Family Service. He has written two

books and about twenty other publications in neurology, psychiatry and psychology.

Dr. Bertram B. Moss of Chicago, Illinois, is Secretary of the Illinois Academy of Criminology, Director of the Illinois Academy of General Practice, and Chairman of its Mental Health Committee. He is also Medical Consultant to the United States Parole and Probation Service, Northern District of Illinois, and member of the National Mental Health Committee of the American Academy of General Practice.

Dr. Edward Podolsky of Brooklyn, N. Y., is associated with Kings County and Coney Island Hospitals in Brooklyn as Assistant Attending Psychiatrist. He is Psychiatrist with the State University Alcohol Clinic, Consultant Psychiatrist with the Baro Medical Center, and Consultant to the National Association of Mental Health. Dr. Podolsky is also an Instructor in Psychiatry, State University of New York, Downstate Medical Center.

Dr. Robert N. Rutherford of Seattle, Washington, is Assistant Clinical Professor in Obstetrics and Gynecology at the University of Washington School of Medicine, and Chief of Obstetrics and Gynecology, Virginia Mason Hospital, Seattle. He is Past President of the Pacific Coast Fertility Society and a member of the Board of Directors of the American Sterility Society. Dr. Rutherford is Executive Editor of the *Western Journal of Surgery, Obstetrics, and Gynecology* and is an active contributor to the literature of obstetrics, gynecology and marriage counseling.

Academy News Notes

DR. MILTON JABUSH, President of the New Jersey Section of the Society for Clinical and Experimental Hypnosis, acted as morning moderator at a Conference on Hypnosis in Medicine and Dentistry, presented by the New Jersey Section, and delivered a paper on "Ante-Natal Conditioning in Pregnancy" with a film. He also recently addressed the Pan-American Medical Convention in Mexico City on the "Untoward Effects of Hypnotic Control in Obesity."

DR. VICTOR SZYRYNSKI is attending the sixth International Congress of Internal Medicine in Basle, Switzerland, August 24-27. He will present papers on psychosomatic aspects of cardiovascular diseases and on diabetic motor neuropathy (with Dr. J. Feller of Ottawa).

DR. RUDOLF DREIKURS of Chicago will present the major report on Psychotherapy at the International Congress of Adlerian Psychology in Vienna on August 29th. He will then be on a lecture tour in Greece and Israel where he will conduct seminars and give lectures at the University and Medical Society.

DR. JORDAN M. SCHER of Chicago is the Editor of the *Journal of Existential Psychiatry*, the organ of the American Ontoanalytic Association. When this was reported earlier in the year, Dr. Scher's first name was erroneously given as Jerome.

DR. BEN-HENRY ROSE won first prize at the recent exhibition of the American Physicians Art Association, held in conjunction with the A.M.A. convention in Miami Beach. His oil portrait of "The Chinese Beggar—Outer Territories of Hong Kong" was also given the popularity award by vote of all people attending the showing.

DR. LEO WOLLMAN, who spoke before the Philadelphia Society of Clinical Hypnosis on June 5, 1960 on "Infertility and Hypnosis" was recently elected President of the Metropolitan New York Society of Clinical Hypnosis.

DR. W. S. KROGER recently addressed the Pan American Medical Association on Hypnosis in Obstetrics and Gynecology. He has three books due: "Childbirth by Hypnosis" (Doubleday); "Psychosomatic Obstetrics, Gynecology and Endocrinology" (Thomas) and "Clinical Hypnotherapy" (Lippincott).

DR. FREDERICK W. GOODRICH, JR., was keynote speaker at the first meeting of the newly formed International Society for Childbirth Education which was held in Milwaukee in May. The title of his speech was "Psychosomatic Obstetrics, 1960."

THE 1961 ANNUAL MEETING of the Academy of Psychosomatic Medicine will be held at the Emerson Hotel in Baltimore, Md., October 12 through 14. The program chairman is George Sutherland, M.D., 3700 North Charles St., Baltimore, Md. The 1962 meeting will be held in Minneapolis, Minnesota, October 24 through 28. Program chairman is Kenneth W. Teich, M.D., 801 Medical Arts Bldg., Duluth 2, Minn.

ALL MEMBERSHIP CERTIFICATES for the year will be presented at the Annual Business Meeting in Philadelphia. Those members who are not present will have their certificates mailed to them.

Items and Reports of Interest and Notes on Training

According to Drs. Myron L. Stein, Aaron Rausen and Abram Blau of the Mt. Sinai Hospital in New York City, psychiatric disturbances can occur in babies from the time of birth—but since a baby's range of behavior is limited, these disturbances are more likely to be expressed as

somatic complaints. In one case reported by the authors (*J.A.M.A.* Dec. 26, 1959) an eight month old baby suffered a mental depression. This was expressed by wasting due to malnutrition and was eventually traced to the mother's depression and her inability to provide love and attention. Rapid recovery ensued when a special nurse was assigned to give the baby love and attention. After this successful venture, the authors decided to develop a "mother bank" of volunteers who would be able to serve as mother-surrogates when needed.

A study of headache in children carried out at Washington University School of Medicine in St. Louis, showed that in 44% there were EEG abnormalities without associated cerebral pathology. According to the authors, Drs. W. A. Froehlich, C. C. Carter, J. L. O'Leary and H. E. Rosenbaum, who reported their findings at the recent meeting of the Academy of Neurology, three quarters of the records showed "slow" disorders, "spikes" were seen in 22% and simple fast tracings in 3%. A fairly close relationship was established between EEG abnormalities and the severity of the headache. A number of children with a negative convulsive history but exhibiting "spike" patterns responded to anticonvulsant therapy.

The Department of Psychiatry at the University of Southern California School of Medicine has started three courses for GP's. One course covers clinical psychiatry, a second covers psychosomatic problems and the third, therapeutic interviewing. The Chairman is Dr. Seymour Pollack of 2025 Zonal Ave., Los Angeles 33, Calif.

The Third World Congress of Psychiatry will be held June 4-10, 1961 in Montreal. Those wishing to present papers should contact the General Secretary, Dr. Charles A. Roberts, Allan Memorial Institute, 1025 Pine Ave., West, Montreal 2, Quebec.

Dr. Matthew Ross, Medical Director of the American Psychiatric Association, in an address to doctors attending the National Health Forum at Miami Beach, suggested that doctors use a variety of psychotherapeutic methods on their elderly patients before making a diagnosis of organic cerebral damage.

Dr. Geoffrey Dean, of Port Elizabeth, South Africa, in a report to *Factor*, the newspaper dealing with the emotional factor in medical practice, stated that in many cases of porphyria a psychiatric diagnosis had been made. The diagnosis depends primarily on the physician's awareness of its existence. Acute intermittent porphyria can usually be recognized by testing for porphobilinogen. Barbiturates and other sedatives can precipitate acute attacks, with paralysis and even fatality.

The Association for the Advancement of Psychotherapy has announced that the first Emil A. Gutheil, M.D., Memorial Conference will be held on Sunday, October 30, at the Barbizon Plaza Hotel, 106 Central Park South, New York City.

The morning program will deal with "Current Concepts in the Management of Anxiety." The speakers will be Gustav Bychowski, M.D., and Lewis R. Wolberg, M.D., New York City, and Lauretta Bender, M.D., Queens Village.

In the afternoon the Emil A. Gutheil, M.D., Medal for Outstanding Contributions to Psychiatry will be awarded to Nolan D. C. Lewis, M.D., Bronx, emeritus professor of psychiatry, Columbia University, who will deliver the memorial lecture. The topic of Dr. Lewis' talk will be "The Future of Psychotherapy."

For further information contact: Stanley Lesse, M.D., Secretary-Treasurer, The Association for the Advancement of Psychotherapy, Inc., 15 W. 81st Street, New York 24, New York.

Members of the Academy who would like to obtain a one-hour taped Audio-Digest of the 1959 meeting can obtain it by writing to Mr. Joel Jepson, Smith, Kline and French Laboratories, 1500 Spring Garden Street, Philadelphia 1, Pa. These tapes were prepared by S.K.F. and are distributed free of charge.

Psychiatrists and internists living in the New York area who are willing to work one morning a week (Fridays) in the newly created Psychosomatic Clinic at Maimonides Hospital of Brooklyn, should contact the editor. Maimonides Hospital is affiliated with the State University Medical Center. It is one of the few institutions that offer this opportunity to work with psychosomatic problems. Both psychiatrists and internists are currently needed.

Abstracted from the Medical Press

A CONSIDERATION OF MULTIPLE FACTORS IN THE ETIOLOGY OF UVEITIS. John K. Erbaugh, M.D., Survey of Ophthalmology, 5: 260-263, June 1960.

This is a well written review of an excellent psychosomatic approach to the problem of uveitis. Since it is a review it is difficult to abstract. An inflammatory disease such as uveitis can be broken down into two interreacting components: an agent and a host. There is individual vulnerability and tissue vulnerability. For example there are inheritable individual differences in the ability to make antibodies. Our knowledge of tissue or organ vulnerability is practically non-existent. To explain tissue vulnerability, in this case ocular vulnerability, the psychologic approach may yet prove the most fruitful. At one unconscious level the eye has one meaning, while at another level it may have an entirely different significance. Probably the eye is one thing to the hysterical amblyope and quite another to the uveitis patient. The hysteric merely shuts off his vision, while the psychotic may remove the eye.

T. F. Schlaegel, Jr., M.D.
Indianapolis, Indiana.

"HYPNOSIS," ANALGESIA, AND THE PLACEBO EFFECT. T. X. Barber, Ph.D., J.A.M.A., Vol. 172, No. 7, Feb. 13, 1960.

The author of this paper attempts to explain how "mere words" spoken by one person to another are able to exert an analgesic effect.

Two factors are responsible. One of these is a placebo effect; the other resembles the mode of action of morphine.

The patient must have confidence in his physician and believe that hypnotic procedures can relieve his pain. The patient must also be able to become inattentive to, not thinking about, and unresponsive to nocioceptive stimuli. The first is the placebo effect; the second resembles relief of suffering achieved with morphine.

Emphasis should be placed on the characteristics of those few persons able to experience a deep hypnotic trance. As a result of previous life experience, they are able quickly and easily to become relatively inattentive to, not thinking about and unresponsive to selected stimuli.

The patient believes that pain will be relieved (hypnosis acting as a placebo effect) and the patient develops a contentment, freedom from anxiety, and a "bemused state comparable to distraction," without altering the intensity of painful sensation or elevating pain threshold (morphine effect).

Joseph Joel Friedman, M.D.
Brooklyn, N. Y.

PSYCHOLOGICAL FACTORS IN THE PRACTICE OF DENTISTRY. Alex H. Kaplan, M.D., J.A. D.A., 57:835, Dec. 1958.

The several topics that are developed within the dental frame of reference include such subjects as anxiety, psychosomatic versus neurotic reactions, emotional factors affecting dental disease, psychophysiological reactions, psychological reactions to dental procedures, the dentist-patient relationship, bruxism and thumbsucking.

The author concluded that "Psychological factors may, as a result of recurring emotional states and anxiety, cause physiological changes and dental disease. Conversely, dentofacial deformities may have a significant effect on the growing personality. But in the majority of patients, emotional factors complicate rather than specifically cause dental disease. Furthermore, the emotional factors influencing the doctor-patient relationship have a direct bearing on the problem of the general treatment of dental disease. Patients may react to dental manipulations with tension or anxiety equivalents such as avoidance, excessive reaction to pain, gagging or irritability. This makes it essential for the dentist to treat the person as a whole, considering his psychological reactions as well as his obvious dental disease. The importance of recognizing that the emotional reactions of patients are usually directed at the oral attack, and not the dentist himself, must be emphasized.

"Besides learning more about normal personality development and its customary variations, the dentist must learn to guard himself carefully against too many frustrations. He must have his own normal emotional needs gratified as the first step in meeting his patients' emotional needs. In order to facilitate his understanding of personality traits and their effect on dental care, it is hoped that theoretical and practical courses on the development of personality and the science of psychodynamics will become prerequisites in all dental schools."

Melvin Land, D.D.S.
Dallas, Texas.

THE EFFECT OF EARLY SURGERY FOR STRABISMUS ON THE PSYCHOLOGY OF THE CHILD. P. Vancea, M.D., P. P. Vancea, M.D., and V. Vaighel, M.D., Ann. Ocul., 192:354-361, May 1959.

The authors point out that the relation between strabismus and the psyche may be considered two ways: (1) psychic troubles as etiologic factors in strabismus; (2) strabismus as a generator of psychic troubles. They stress the fact that strabismus should be corrected before it can produce psychic upsets, that is, before family and school surroundings arouse in the patient the consciousness of his infirmity. They report on a series of 17 children operated before the age of four with excellent results in all cases.

T. F. Schlaegel, Jr., M.D.
Indianapolis, Indiana.

A REHABILITATION PROGRAM FOR GERIATRIC PATIENTS. H. Blustein, J. Amer. Geriat. S., 8:204, March 1960.

This article was presented before the Sixth Annual Meeting of the National Geriatric Society, Chicago, April 19, 1959.

A plan for the rehabilitation of elderly men on the Geriatric Service of a Veterans Administration hospital had as its objective the remotivation of patients showing mental regression and antisocial behavior to get them to attain the fullest life possible in view of their abilities and disabilities. A team approach was used and internal medicine, neurology, psychiatry, nursing care, physical, corrective, occupational and recreational therapy all contributed to the program. The men responded well to the attempt at total rehabilitation by showing an improvement in physical condition and mental status.

Anthony R. Tortora, M.D.
Brooklyn, N. Y.

PSYCHOPHYSIOLOGY OF HYPNOSIS. Louis J. West, M.D., J.A.M.A., Vol. 172, No. 7, Feb. 13, 1960.

Dr. West broadens the concept of dissociative reaction. Data concerning the physiology of awareness indicate a mechanism capable of scanning and screening incoming information and regulating the sphere of awareness moment by moment. Only a minute amount of the total available information (from the external environment and from within the brain itself) can be held in awareness at any given time.

Scanning and screening is constantly necessary to focus on selected material and to keep everything else out of awareness. This makes possible concentration and a "dissociation of awareness from the majority of sensory and even strictly neural events that are taking place." This quote is Weitzenhoffer's recent definition of hypnosis and implies an appreciation of the combined functions of focus and exclusion; between excitation and inhibition.

The brain system which permits integration of incoming stimuli and awareness to them is the ascending reticular activating system and the thalamocortical projection system. Stimulation, inhibition, arousal and depression are all managed in the reticular formation. This area subserves the reality-testing functions of the ego. Focus of awareness may be narrowed down to one particular aspect of reality (as in the initiation of the hypnotic trance), and sensory data (verbal suggestion) becomes more effective.

The reticular activating system may act in two ways: The first in which attention is fixed by a narrow range of stimuli, monotonously presented; the second in the non-acceptance of nearly all additional incoming information in the presence of an input-overload.

Deliberate exclusion of external stimuli may be achieved through intense concentration. This is possible through the focusing and inhibiting ability of the reticular system. It is probably in this way that the trained subject quickly enters the trance state on receiving his learned signal.

Phenothiazines render the chronically anxious patient more accessible to hypnosis; phenobarbital will not.

Joseph Joel Friedman, M.D.
Brooklyn, N. Y.

USE OF PROTAMIDE IN THE TREATMENT OF HERPES ZOSTER. A. G. Baker, Pennsylvania Med. J., 63:697, May 1960.

A variety of remedies have been used in the treatment of herpes zoster ("shingles"), including antibiotics, vitamin B complex, cyanocobalamine (vitamin B_{12}), corticosteroids, vasodilators, sulfonamides, immunoglobulin, and symptomatic drugs such as analgesics and antipruritics. They provide only limited benefit and many may induce undesirable reactions. The report presents observations concerning the incidence of postherpetic neuralgia and the duration of pain, disability, and skin lesions in 34 cases of herpes zoster treated with Protamide, a denatured proteolytic enzyme, and compared with 10 patients of the same age groups treated with cyanocobalamine (vitamin B_{12}).

Protamide injections (1.3 ml.) were administered intramuscularly at 12 to 24 hour intervals on the first two days and thereafter one injection on alternate days. Treatment was continued

from 5 to 16 days depending upon severity of symptoms.

Cyanocobalamine was administered 1000 micrograms daily by hypodermic injection and treatment continued one to two weeks.

Good to excellent results were seen in 32 of 34 cases treated with Protamide. Patients treated with cyanocobalamine showed equivocal results.

S. Z Haidri, Ph.D.
Detroit, Mich.

PSYCHOSOMATIC ASPECTS OF INFERTILITY. Theodore E. Mandy, M.D., and Arthur J. Mandy, M.D., Sinai Hosp. J., 8:28-35, 1959 (Baltimore).

In cases of infertility, emotional factors should be assessed if no organic disease is apparent. Investigation should include the following questions: 1) Why does she want a child? 2) What will having a child mean to her? 3) What was the relationship of the patient to her mother in childhood and what is it at the present time? 4) What was her relationship to her brothers and sisters, and 5) What is her marital history?

A woman with functional infertility may desire pregnancy to satisfy her husband's demands, to try to correct a shaky marriage, to have a child so that someone would love her, or to show her own mother how to raise a child.

Ambivalent feelings about having a baby, and a conscious or unconscious rejection of motherhood may be present. When rejection is unconscious, shifting from one physician to another is common, as are the symptoms of menstrual irregularity. Most of these patients are immature and dependent; the dependency may be marked by aggressiveness.

MENTAL DISORDERS IN CEREBRAL CYSTICERCOSIS. R. Jeri, Rev. psiq. peruana, 1:211-227, 1958.

A total of 28 of 32 patients with cerebral cysticercosis showed mental disturbances. All patients showed symptoms pointing to a cerebral lesion (headache, convulsions, visual disorders, paresis, etc.). Mental symptoms consisted of personality changes, acute delirium and psychotic reactions. In some the diagnosis of schizophrenia or manic-depressive psychosis had been made prior to neuropsychiatric observation.

ULCERATIVE COLITIS AND PREGNANCY. Edward L. Krawitt, Obs. and Gyn., 14:354-61.

A review of the literature revealed that more than one third of quiescent ulcerative colitis patients are activated by pregnancy and half of the active cases are aggravated. Approximately one fourth will improve with pregnancy.

The interrelationship of the two conditions is thought to be psychogenic. The course of the colitis is determined by the expectant mother's attitude towards her pregnancy. She usually is emotionally immature, cannot tolerate frustration or assume responsibility; pregnancy therefore constitutes a stressful situation threatening her dependent status.

(Quoted in World-Wide Abstracts, Vol. 3, No. 2, Feb. 1960.)

THERAPY OF HYPERTENSION WITH ORALLY GIVEN SYROSINGOPINE. G. R. Herrmann, et al., J.A.M.A., 169:1609-1612, April 4, 1959.

Syrosingopine (Singoserp, Ciba) is a synthetic compound derived from reserpine. It was prepared with the hope of removing undesirable side reactions. The study considered 77 patients with essential hypertension. Of 38 patients who had no previous therapy for hypertension, 16 (42%) responded with a clinically significant drop in blood pressure. Thirty-four patients who had previously received reserpine were changed to syrosingopine and were controlled without side effects. In five patients who had severe mental depression or severe nasal congestion on other Rauwolfia products, a hypotensive effect was now seen without these side effects on a dose of 3 mg. per day.

ACUTE BRAIN SYNDROME. I. J. Farber, Dis. Nerv. System, 20:296-299, 1959.

The most common manifestations of the acute brain syndrome are delirium and defects in the sensorium, but delusions and behavior changes may be seen. The most common causes, excluding alcoholic hallucinosis and delirium tremens, include convulsive disorders, drug intoxication, circulatory disturbances, systemic infections and head trauma.

Disorientation is frequent, more often in relation to time than to place. Memory disturbances may be diffuse or isolated and may be for recent or remote facts. Auditory hallucinations are more common than visual ones. Ideas of persecution may be present as well as depression or signs of increased anxiety and irritability.

In patients where the delirium is of unknown etiology, autopsy may reveal one of the following: Wernicke's encephalopathy, frontal lobe abscess, tuberculous meningitis, or a cerebrovascular accident.

W. D.

Psycho-Pharmaceuticals and the New Look in Psychiatry

With each psycho-pharmaco-chemical find,
It seems that psychiatry's losing its mind.
Each gain toward a physiological goal
Creates some new loss of philosophy's soul.
And breaching brain-barriers by new dialysis
Undermines bastions of psycho-analysis,
While lab-tests for paranoids, manics or schizics
Restrain the grand sweep of age-old metaphysics.
With the mind a revamped neuro-chemical entity
Psychiatry has a new look and identity.

Since these are the facts, doctors can't be obsessive,
But must learn what's new if they would be progressive.
The old disciplines (so well tried, true and trusted)
For psychos, neurotics and the maladjusted,
Still saddle the doctors with so great a strain.
It's lucky they all don't get "head-shrinker's brain,"
For neurotics get well tho' they make doctors ill,
Who could safeguard their health with a pill for a pill,
Thus using a sort of mental homeopathy,
Avoiding thereby self-induced grave neuropathy.

Now when energy wanes or depression is chronic,
To-day's spirit favors no old-fashioned tonic.
With new pharmaceuticals doctors act wiser
By speeding up cures with a fast energizer,—
And patients a-twitter with nerves all a-jitter
Can use tranquilizers, calm down and be fitter,—
While some sail thru space, of all earth's shackles freed
By lysergic acid diethylamide,
Past "Doors of Perception" and Huxley's sensations
To realms of weird fancies and hallucinations.

The flights are far higher, far stranger the scenes
Than can be expected from amphetamines,—
Yet these and the hydrazines do elevate
With vigor, but cause no confused mental state.
These great wonder drugs are the chemist's fine gift
That can help you relax or give you a lift.
They shorten some treatments, make others less drastic,
Tho' new, they're established,—not iconoclastic.
With these potent aids doctors needn't be slouches,
They all can be tops without recourse to couches.

Sam Silber, M.D.
Brooklyn & Belle Harbor, N. Y.

Book Reviews

TRANSACTIONS OF THE FIFTH ANNUAL MEETING OF THE ACADEMY OF PSYCHOSOMATIC MEDICINE: The Psychosomatic Aspects of Internal Medicine. Wilfred Dorfman, M.D. (Ed.), New York, Academy of Psychosomatic Medicine, 1958, 268 pp.*

The task of such a vast number of communications as is represented in this ambitious volume is etremely difficult, to say the very least. When the editor has also been responsible for the program, he has indeed earned a generous vote of thanks from the many participants in the program and the large and appreciative audience.

The Academy of Psychosomatic Medicine has begun to fill a real need which for some years has been felt by the more enlightened general practitioners and by many specialists. This is felt especially by those whose relative isolation from university medical centers makes difficult contact with changing concepts of disease and of the mutual interaction of psyche and soma in the etiology and complications of bodily disorders. The scope of the program whose transactions are the subject of this review is sufficiently broad to interest many different groups of workers in medical practice, research, and community organization. The program includes three major symposia, entitled "Mental Health and the General Physician," "Depression and Psychophysiological Disease," and "Psychopharmacology."

In addition to these symposia which include a few presentations of considerable scientific interest as well as several that offer excellent practical suggestions to the general practitioner, there were no less than 10 panel discussions ("The Recognition and Management of the Borderline Psychotic;" "Cholesterol Metabolism, Coronary Disease and Stress;" "Goals in Treatment;" "Psychiatric Referral;" "Emotional Aspects of Somatic Disease and Disability;" "The New Psychotherapeutic Drugs: Their Use and Misuse;" "Hypnosis;" "Depression;" and "Psychotherapy").

Strikingly absent from the list is any panel discussion or individual paper on the present status of shock therapy. In more than one paper the comment is made that it has been replaced largely in many forms of depressive reaction by the use of modern drugs, single or in combination.

The title of this volume, *The Psychosomatic Aspects of Internal Medicine*, seems to this reviewer unnecessarily tautological, since if internal medicine as a specially informed branch of medical practice is not concerned with the organism as a whole, it can hardly be considered worthy of rating as a specialty. It would seem preferable to use such a title as *The Place of the Emotions in the Diagnosis, Prognosis and Treatment of Illness*. The old confusion as to the meaning and value of the term psychosomatic is revealed in the following exchange which took place during the discussion of the role of Cholesterol in the production of atherosclerosis.

Dr. K.: "I visualize psychosomatic as referring to the affect or response of an individual to a stimulus which is out of range of the normal response to this stimulus. For example, the response of a patient to a placebo would be a psychosomatic response regardless of what his response would be."

Dr. Z.: "The term psychosomatic has always impressed me with the fact that we are dealing with a new term. Actually, we are dealing with a patient who is neurotic, whose symptoms are those of neuroticism; and while he may have somatic symptoms it is the psychic symptoms which are accentuated. It would seem, therefore, that the term psychosomatic is somewhat ambiguous."

Dr. B.: "Strangely enough, I don't have that concept of it at all. What my concept of psychosomatic is, is that it is really taking the patient as a whole, taking mind along with the body, which we feel has been neglected. I think it is important to consider it as a whole."

As might be expected, the symposia were well planned, with the discriminating selection of participants, and were both interesting and informative. The panels also, for the most part, were of a high order, although some were more timely than others. There was only one paper on endocrine therapy, its use and misuse, by Doctors Herbert S. Kupperman and William Greifinger. This was full of practical clinical information and was richly illustrated.

In a research study made by Eric Wittkower and J. L. Lapointe, the difficulty of carrying out effective education in the field of cancer prevention was strikingly demonstrated. This study brought out resistances familiar to those who have attempted to educate the lay public to a sympathic understandinng of programs of preventive mental health.

A painstaking study of the relation of epinephrine and norepinephrine to psychophysiologic disease was presented by William M. Manger and his associates. This report was accompanied by a complete bibliography, as was true also of an exhaustive summary of chemical concepts in psychosomatic medicine presented by John C.

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Saunders. In this paper (a polemic for the biochemical origin of mental (disorders) the usual contempt of the biochemist for any concept of psychogenesis as a primary etiologic agent was forcefully expressed.

An excellent paper entitled "Practical Considerations in the Management of Psychosomatic Problems" was contributed by Dr. Zale A. Yanof. This made a good companion piece to the paper "Current Theoretical Concepts in Psychosomatic Medicine" by Doctors Harold and Helen Kaplan.

Special mention should be made of the symposium on "Depression and Psychophysiologic Disease," which was spearheaded by an exhaustive coverage of the various depressive syndromes: their symptoms, the physical and laboratory findings, the precipitating factors, the principal psychodynamics, and the principles and methods followed in therapy, by Dr. Franklin G. Ebaugh. The presence of such notable contributors to the literature as Edward Weiss and Sandor Rado made for a varied and stimulating discussion.

Theodore Rothman gave an excellent account and critique of the various methods used to teach general practitioners the fundamental concepts underlying the psychosomatic or holistic approach to the study and treatment of human illnesses. In a later paper he presented a challenging point of view on the possible reasons for failures in psychoanalytic and psychotherapeutic efforts to cure patients characterized by inhibition in communicating feelings to their therapists. To a seemingly well-reasoned critique of his conclusions by Dr. Howard Davidman, Dr. Rothman wrote a scorching denunciation of those comments in rebuttal. Dr. Rothman stated that he had found that many patients, unsuccessfully treated over many months or years by psychotherapists of one stripe or another, had been considerably benefited by the preliminary induction of pharmacotherapy. He had used a combination of thiopental and methylphenidate, which succeeded in large measure in overcoming the resistance to free communication and so facilitated the psychotherapeutic process. His method finds a parallel in that reported by Leo Alexander.

In the papers devoted to the need for better communication between general practitioners and psychiatrists, there were some minor differences in emphasis. In an excellent paper presented by Dr. Mortimer Sackler, he recommended that a patient "be referred to the psychiatrist for diagnostic evaluation whenever any serious doubt exists as to the nature of the mental disturbance." He went on to suggest in a later paragraph that "while it is the psychiatrist who may make the diagnosis, continuing biologic or chemical replacement or substitution therapy may best be administered and closely followed by the general practitioner." This is a very nice point. As in so many other questions involved in the matter of referral of patients for psychiatric advice, the individual factor must determine procedure and the distribution of responsibility. Some general practitioners may be better equipped than some psychiatrists to prescribe and follow up drug therapy; by the same token, however, the opposite may be the case. After all, most of the significant research into the action and practical uses of the "tranquilizing" and and "energizing" drugs has been carried out within the confines of mental hospitals by psychiatrists and research workers who work under their authority.

To sum up, this volume, although somewhat lacking in arrangement, contains an enormous amount of interesting and stimulating material, some of it in formal papers, some in free discussion. The Academy has offered a challenging and informative program which should be of interest to all but those who are in the upper echelons of the investigative and teaching staffs in our medical schools. The Academy has found a way of supplementing and expanding the work started by the Psychosomatic Society, whose programs of necessity have become more concerned with the finer problems of basic and clinical research than with the practical problems of diagnosis and therapy which face the medical practioner in his daily work. This reviewer has had the privilege of participating in the program for the second time and in reviewing this volume has found much to stimulate ideas to implement further research in the field of comprehensive medicine.

John A. P. Millet,
New York, N. Y.

THE ETIOLOGY OF SCHIZOPHRENIA. Don D. Jackson, M.D., Editor. New York: Basic Books, Inc., 1960. 456 pages. $7.50.

This book, composed of six parts and fourteen chapters, is a fairly exhaustive discussion on the subject given in the title. Each chapter is written by a different author and covers the problems of genetics, biochemistry, physiology, psychology, and family dynamics.

On page 13, the introduction states:

1. "There are those who see schizophrenia as a strictly organic disease with its own periodicity. Causative factors include constitution, heredity, bacteria, parasites, glandular malfunctioning, etc.

2. "There are those who view schizophrenia as primarily an organic disorder which cripples the individual's attempt to deal with ordinary life stresses. In short, his biological vulnerabil-

ity is too great to be compatible with life and the world.

3. "There are those who see the schizophrenics as individuals biologically incapable of coping with major environmental stresses. Major stresses may include such things as adolescence, marriage, parenthood, or it may be assumed that the schizophrenic encounters unusual stresses because of his particular environment.

4. "There is a group who view schizophrenia much like a psychosomatic disorder in which major stresses produce internal changes which in turn bring about further changes, lower adaptive levels, etc.

5. "There is a group of investigators who see the schizophrenic as a regressed individual who withdraws before an onslaught of severe psychic trauma inflicted at a very early age and revivified by developmental environmental factors.

6. "There are investigators who view schizophrenia as a subtly occurring maladaptation which in some sense is appropriate to the covert operations of the family group.

7. "There could be a group, but as far as I know it has no adherents, who would view schizophrenia as essentially a psychogenic disorder but who would see the various forms of its expression—catatonia, paranoia, etc.—as hereditarily determined."

Anyone interested in the subject of emotional disturbance, and especially of this most disturbing of all illnesses, will find this volume well worth studying.

James L. McCartney, M.D.
Garden City, N. Y.

THE HEALING TRANCE. Alan Mitchell. Barnes & Co., 1960. 248 pages. $3.95.

This book, first published in England, was written to explain modern medical hypnosis to the layman. The author, a journalist, describes the experiences of a doctor who takes a course in hypnosis and then uses it in his practice. This is done in narrative form. Most of the common hypnotic phenomena are described and their application in therapy is illustrated. While there is no actual exaggeration, the therapeutic successes might well seem sensational to a layman. Very little is said about failure and the dangers of hypnosis. However the book could be recommended to selected patients for explanatory purposes or as a means of conditioning for hypnotherapy.

Frederick W. Goodrich, Jr.
New London, Conn.

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